DETROIT DHWP
DEPARTMENT OF HEALTH & WELLNESS PROMOTION

Office of the Deputy Director

July 27, 2005

Comments to the Childhood Lead Poisoning Prevention and Control Commission

Chair: Honorable Kimberlydawn Wisdom, MD
Michigan Surgeon General

On behalf of the Honorable Kwame M. Kilpatrick and Dr. Noble Maseru, Health Officer of the city of Detroit, the following comments are given to this body for consideration. The Detroit Department of Health & Wellness Promotion (DHWP) believes that all children should be tested for the presence of lead in their blood before the age of six. DHWP is committed to the elimination a truly preventable disease in the city of Detroit. The DHWP Childhood Lead Poisoning Prevention and Control Program has worked diligently to bring community, local, and state organizations together to collectively develop a plan to address the problem of childhood lead poisoning in the city. The mission of the Childhood Lead Poisoning Prevention & Control Program is the prevention of childhood lead poisoning, identification and treatment of lead burdened children, and facilitation of reducing environmental lead hazards in the home. We are steadfast in our resolve to complete the workplan of our citywide Strategic Lead Elimination Plan. This is our guide to move the city toward the goal of eliminating childhood lead poisoning by the year 2010. The Mayor of the city of Detroit, fully supports this plan.

DHWP is proud of the progress and initiatives made thus far in addressing the childhood lead poisoning. DHWP has:

- Implemented a universal testing policy of all children under six years of age,

- Implemented comprehensive case management protocols that include home visits, lead inspections, and risk assessments,
- Maintained our surveillance system for data accuracy,
- Distributed educational materials and provided presentations to community groups and professionals,
- Developed a primary prevention program for pregnant women and families without lead-poisoned children, and
- Established a HEPA vacuum loan program for Detroit residents.

DHWP recently forwarded language to the Council of the city of Detroit for an ordinance on testing children before entering school. DHWP notes that while this is important, it is much too late for reducing overall damage to children with elevated blood lead levels. Because the risk of lead exposure and rates of lead poisoning are so high in the City of Detroit, by the time children even enter nursery school, they may already have suffered irreparable and irreversible brain damage. The U.S. Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics highly recommend that children have a blood lead test at ages 6 months, 1and 2 years. Therefore, current DHWP "annual testing policy" for Detroit kids younger than 6 years old still makes the most sense, from a lead poisoning diagnosis, treatment, and prevention perspective.

One can argue that the value of making the school aware of a child's EARLY (and not current) blood lead level (BLL) is that the classroom teacher can be monitoring for the learning & behavior problems that may have resulted from lead exposure earlier in life.

Thus, blood lead tests should be done by the child's primary care provider as part of the child's routine health care. If the provider does not have the capacity to perform the blood lead test, then the appropriate referral must be made to have the test done by the Detroit Department of Health and Wellness Promotion. If the child does not have a physician or does not have medical insurance, the test can be done by the Department of Health and Wellness Promotion through the Detroit Childhood Lead Poisoning Prevention Program.

In the July, 2005 MDCH Medicaid Lead Testing report, 2 year old children tested on or before their 2nd birthday and 3 year old children tested on or before their 3rd birthday, respectively, are as follows:

– 45% Statewide – 50% Statewide
– 60% City of Detroit – 71% City of Detroit .

Even with this impressive success, DHWP and the city of Detroit continue to move forward.

DRAFT LANGUAGE:

In accordance with Michigan Public Health Code Section 333.2428, under the powers of the Department of Health & Wellness Promotion's health officer and mandated by the Council of the city of Detroit:

> Children living in the city of Detroit between the ages of 6 months and 6 years shall be tested for lead poisoning on an annual basis.
>
> Blood lead tests for children age 3 and younger shall be tested at 6, 12, 18, 24, and 36 months **or** at 9, 15, 24, and 36 months.
>
> Children ages 4 through 6 years with prior blood lead levels less than 10 micrograms per deciliter shall have an annual assessment.

Furthermore, the City of Detroit has a high number of old deteriorating housing units throughout the city. Old deteriorating housing units are the main source of lead poisoning among children that are younger than six years of age. The use of lead-based paint in residential housing was banned in the United States in 1978, consequently, most of the houses built prior to 1978 contain lead-based paint. Although houses predating 1978 pose a high risk for exposing young children to lead, houses built prior to 1950 pose an even greater risk, due to the higher content of lead in the paint. As the city of Detroit reached its peak in 1950s the construction of

housing structures increased to accommodate the population growth. As a result, more than half of the housing stock in the city was built prior to 1978.

Pursuant to Public Acts 433 and 434 (aka, Lead Safe Housing Registry), this ordinance shall provide:

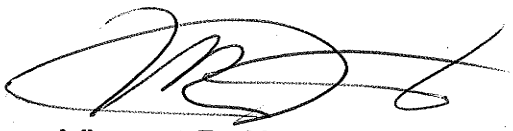
- mandatory "Lead Safe Work Practices" training for all contractors and skilled tradesmen (such as painters, wood workers, etc.) in the city;

- mandatory use of certified lead workers to do ANY repair work in a dwelling where a child became poisoned;

- annual surveys or visual inspections of ALL public and private day care & nursery settings, especially those built before 1978.

Finally, DHWP is working with the Wayne County prosecutor's office, the State of Michigan, Centers for Disease Control & Prevention, the US Department of Housing and Urban Development, and the US Environmental Protection Agency in developing cases for potential litigation in complying with applicable laws and statutes.

Respectfully Submitted:



Vincent R. Nathan, PhD, MPH

kids cops clean™

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Michigan League for Human Services

Testimony of Ann Marston

Before the Childhood Lead Poisoning Prevention and Control Commission

Tuesday, August 2, 2005
Lansing, MI

Good morning. My name is Ann Marston and I am the President and CEO of the Michigan League for Human Services.

As you may know, the League is a statewide policy organization with over 1,500 organizational and individual members from Michigan representing a wide range of interests. Our activities include research, analysis, public education and advocacy on behalf of low-income individuals and families. I would like to thank you for the opportunity to comment today on issues related to childhood lead poisoning prevention in Michigan.

As advocates for low-income families, we would like to encourage the Commission to address the issue of poverty in its deliberations. Poverty among children in Michigan jumped by 14 percent between 2000 and 2003, according to the latest national Kids Count report. Poverty compounds the vulnerability of children to lead poisoning because they are less likely to have regular meals rich in calcium and iron to help protect against the absorption of lead dust. These children are also more likely to live in lead contaminated housing, usually the older minimally maintained rental properties in our older urban and rural areas. They also depend on Medicaid to access health care. We would urge the Commission to take a public position about current budget proposals that would require premiums and co-pays for Medicaid-eligible families. More than one in four children in the state depend on Medicaid for health care. Such surcharges would curtail access to preventive care now in place to test and treat these high-risk children. When the Governor's Task Force on Childhood Lead Poisoning was meeting, these proposals to solve the state budget shortfall by imposing such burdens on poor families in order to access care had not been made. Rather than limiting access to health care, we encourage the Commission to improve testing and follow-up requirements particularly for children in high-risk communities through legislation and/or rule making.

Poverty in Michigan exists in every corner of our state. It is not just an urban problem but a rural problem as well. A recent analysis of rural children in Michigan and the U.S. showed that 13 percent of children in Michigan's rural areas are in poverty, compared to 14 percent statewide. Over 100,000 children in Michigan live in a family where no parent has employment, and one of three lives in a family where no parent works year-round full-time. These are difficult times for

Michigan families, but the need for preventive health care and adequate nutrition is today in the lives of children.

Another concern is the 155,000 children who live in families dependent on the cash assistance grant, which has lost one-third of its purchasing power since 1993. Proposed legislative budgets would lop off roughly 10 percent of the maximum grant payment, bringing it down to $409. These same families would be expected to find the resources to pay Medicaid premiums and co-pays. With the freeze not only in the grant level but the eligibility, the program has become inaccessible to many working poor families. A family must be at a much lower level of poverty in order to qualify. In 1993, the maximum FIP cash assistance level after the earned income disregard brought a single working mother with two children up to 81 percent of the poverty level; by 2004 it only brought the family to 61 percent of poverty income. Such policies leave many families who are well below poverty ineligible for assistance and their children vulnerable to hunger. Food stamps will not make up the difference as the amount is predicated on the assumption that they will cover only two-thirds of a family food budget.

The state legislature must address the structural deficit that is compromising the ability of the state to meet the needs of its citizens in the 21st century not by continuing to make cuts that threaten the health and well-being of children but by exploring revenue options to replace resources for programs that address poverty. To meet the goal of eliminating childhood lead poisoning by 2010, the state must maintain a commitment to ensure access to preventive health care for all children.

Michigan must look to revenue solutions to the current budget crisis. We cannot afford proposed reductions such as the Senate's $500,000 in the childhood lead poisoning prevention program at the Department of Community Health (DCH) and the cuts to the Michigan Childhood Immunization Registry (MCIR). These cuts will seriously hamper efforts to address lead poisoning among children.

Rather than cutting the funding for the Michigan Childhood Immunization Registry (MCIR), we encourage the Commission to initiate legislation that would integrate childhood lead testing into the database at an estimated cost of $200,000. With the MICR, Michigan has brought its immunization rate for one and two-year-olds from dead-last to level with the national average.

I have provided copies of a recent League analysis titled *Family Needs Increase While the Safety Net Erodes* for your review. In addition I have provided copies of the recently released 2005 national Kids Count data book, which presents an overview of child well-being in Michigan in comparison with other states in the nation.

The League believes that resources can be found to fund programs and services that contribute to outcomes that are identified as important priorities for the State of Michigan.

Lead-Safe NOW!

testimony to the
Childhood Lead Poisoning Prevention and Control Commission
August 2, 2005

PURPOSE:
Lead-Safe Now! is a multi-agency/multi-person collaborative whose purpose is to end childhood lead-poisoning in Muskegon County.

MISSION:
Our mission is to engage organizations and individuals in productive discussion, planning and action to prevent future events of lead-poisoning.

A LEAD BURDENED COMMUNITY:
Muskegon County is one of the 13 high risk counties as designated by the State of Michigan. Statistically we are seeing a large concentration of children with elevated blood lead levels (EBL's) in the cities of Muskegon and Muskegon Heights.

According to data in the City of Muskegon's 2005-2006 Action Plan, youth in Muskegon are at high risk for lead poisoning for a number of reasons including the following:

- 97% of the City's housing units were built before 1979
- 12% of the City's housing units are estimated in substandard condition
- 26% of the City's households are below the poverty level
- 41% of the City's housing units are rental with many concentrated in the inner city

According to data from the Michigan Department of Community Health:

> Nearly 6%, about 1 out of 20, of the children tested in 2004 in the City of Muskegon had EBL's that were at or above intervention level.
>
> In tracking the highest risk areas that number jumps to 25%, or 1 out of every 4 children tested had an EBL.

ANGER AND PASSION

In speaking with community members the two emotions that seem to be the most predominant are anger and passion.

Muskegon County's parents have voiced anger for the lack of awareness of "what exactly is lead poisoning?" Angered, because of the lack of State funding to test more children, especially for families that are uninsured and also angered for the insufficient amount of support services to help them nurse their children back to better health.

Landlords and realtors have voiced their anger because there has been a dramatic increase of law suits in our area alleging lead poisoning from their homes and because of the high cost of abatement.

There has also been an intense passion for change. This passion has caused parents, grandparents, human service agencies and government entities to collaborate together to seek out solutions. We are learning that childhood lead poisoning prevention must be tackled by the community through a collaborative effort. No one organization can do it all and from this understanding has emerged our present collaborative Lead-Safe NOW!

HOPE FOR THE FUTURE

Lead-Safe NOW! is encouraged by the creation of the Commission and by the State's support of our emerging collaborative in Muskegon County.

The people of Muskegon County are depending on the State of Michigan to follow through in creating a Public Health Trust Fund as called for in the November 2004 Task Force Report.

Also to build upon the 2004 legislation creating a statewide Lead-Safe Housing Registry by enacting legislation to make the Lead Safe Housing Registry mandatory for all rental properties by 2012.

We also call upon the Michigan Legislature to restore the $500,000 in funding cuts for childhood lead poisoning prevention being called for in the Senate budget for the Department of Community Health.

We call upon the Michigan Legislature to restore full funding for the Michigan Childhood Immunization Registry (MCIR) and keep this important tool under the management of the DCH.

Respectfully Submitted,

Tressa Duncan
Project Coordinator

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MCIR
Michigan Childhood Immunization Registry

Michigan Department of Community Health
MDCH
Jennifer M. Granholm, Governor
Janet Olszewski, Director

MICHIGAN CHILDHOOD IMMUNIZATION REGISTRY
BACKGROUND FOR MICHIGAN

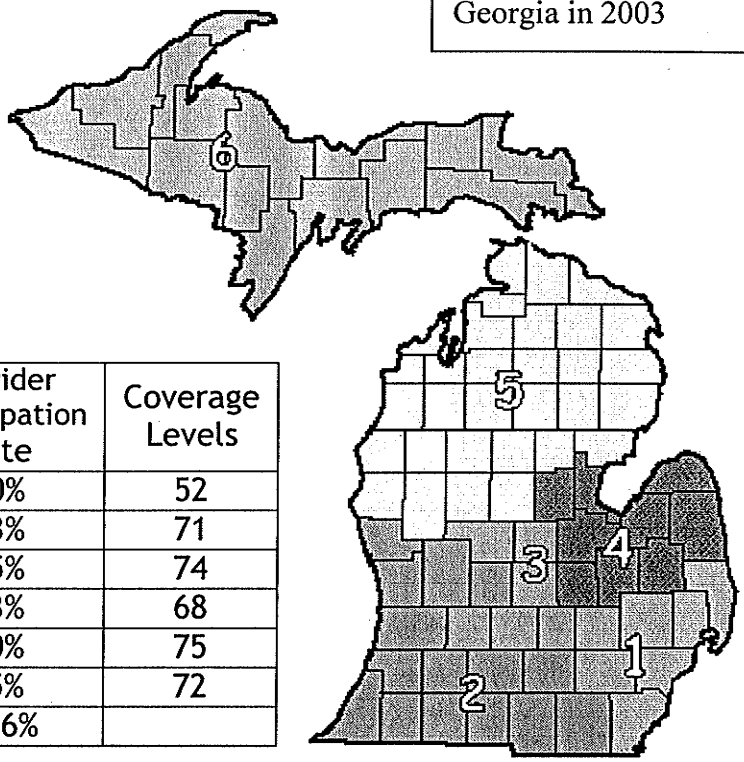
Ages:	0 - 20 years
Geographic Area:	Statewide
Years In Operation:	9
Reporting Mandated:	Yes
Annual Birth Cohort:	135,000
Number of Patient Records:	2.8 million
Number of Immunizations:	40 million
Number of Providers Contributing Data:	2,203
% Provider Participation	85%
Type of Registry:	Oracle Database
Pending improvements:	Open MCIR to over age 20; Integrate MCIR with other health data

2,481 Private Provider Offices utilize MCIR

422 Public Health Facilities utilize MCIR

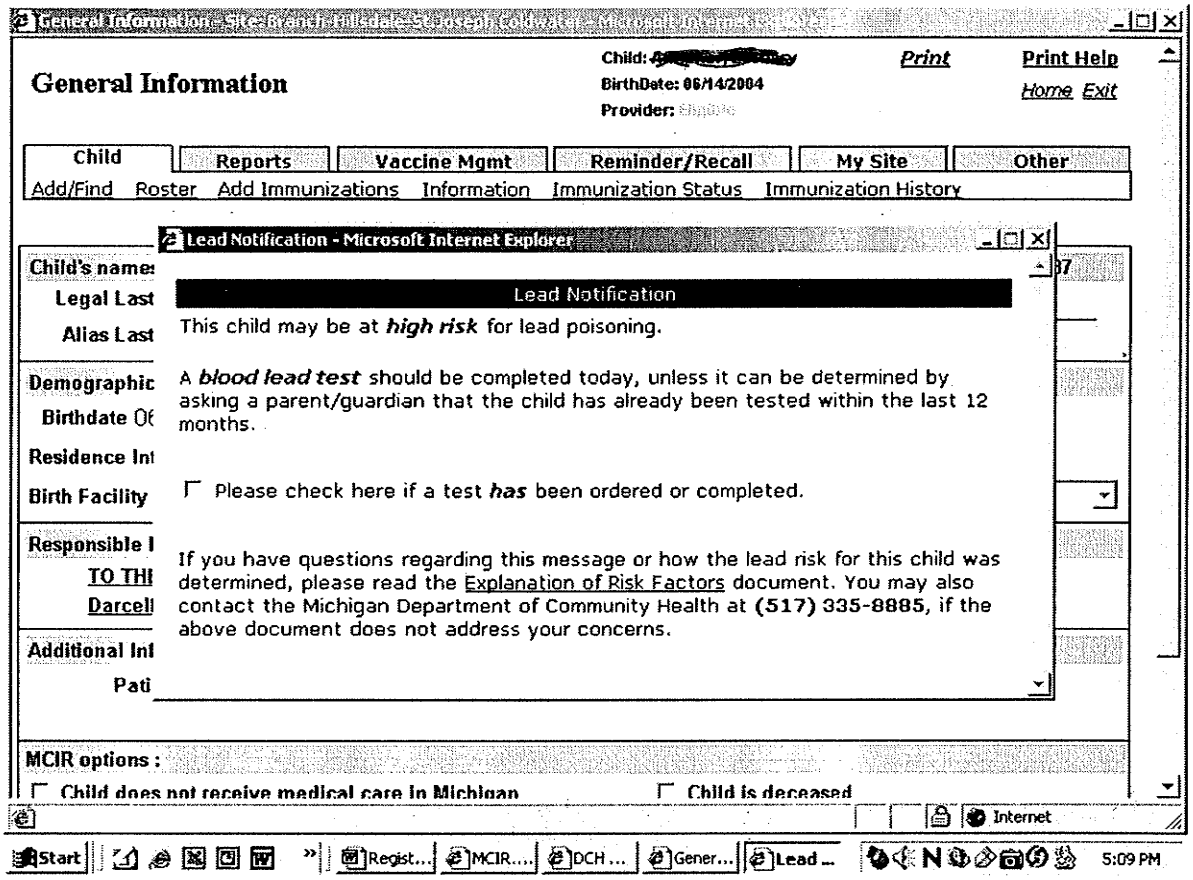
Michigan received from CDC the *Grow* and *Protect* award at the National Immunization Conference in Atlanta Georgia in 2003

5,000 users access MCIR every day. There are 500 simultaneous users on MCIR from 7am to 7pm every weekday.



Regions	# of Counties	# of Providers	Provider Participation Rate	Coverage Levels
1	7	1,100	80%	52
2	15	540	93%	71
3	6	345	95%	74
4	9	344	93%	68
5	31	254	80%	75
6	15	240	95%	72
Sentinel	76	1,179	91.6%	

August 2, 2005



MCIR initiates the above lead notification pop up window if children are identified with either of the following criteria:

1. Live in a high-risk zip code zone.

OR

2. Have a Medicaid ID.

Therese Hoyle
State MCIR Coordinator
Division of Immunization 517-335-8159
Michigan Department of Community Health
August 2, 2005

MCIR
Michigan Childhood Immunization Registry

Michigan Department of Community Health
MDCH

Jennifer M. Granholm, Governor
Janet Olszewski, Director

RPOA of Michigan
Report to the Childhood Lead Poisoning Prevention and Control Commission
August 2, 2005

Thank you for enabling the Rental Property Owners Association of Michigan to offer its position to the Commission.

The Rental Property Owners Association of Michigan recognizes the hazards created when children under the age of six are exposed to lead-based paint dust. We also understand that many homes—owner occupied and rental housing--built before 1970 contain lead paint. We further agree with the conclusions of the scientific community that addressing the many factors contributing to the possibility of a child becoming lead poisoned is critical to the elimination of this public health issue.

Rental property owners throughout the State are committed to practices that significantly lower children's exposure to lead hazards. We are also committed to providing our tenants with the information they need to make informed decisions regarding their housing choices and personal choices regarding housekeeping and other factors related to the protection of children from hazards created from the exposure to lead dust.

Rental property owners have made great strides in this effort over the last five years, including:

- providing information to tenants about the risk of lead based paint hazards and things that tenants can do to reduce their children's exposure to lead paint dust;
- disclosing the nature of lead based paint hazards contained in a rental property at the time of leasing;
- following the pre-rental property maintenance guidelines developed through our partnership with the Michigan Department of Health;

- firmly encouraging rental property owners to maintain their housing up to the standards of property maintenance codes;
- supporting and working closely with the Department in the creation of new laws, including the lead-safe housing registry and new regulations regarding the penalties inherent to the refusal to remove of lead hazards where a child has been found to have lead poisoning;
- by actively seeking legislation that would provide the economic tools necessary for property owners to address lead-based paint hazards while maintaining affordable housing;
- and by actively participating in the Childhood Lead Poisoning Prevention Program.

While rental property owners strongly support these and many of the efforts fostered by successful programs such as Get the Lead Out! in Grand Rapids, we want to make it perfectly clear that mandated aggressive laws dealing with lead paint would be disastrous for the housing industry. For example: requiring the removal of all lead paint or the replacement of all structural elements contributing to lead hazards would create a tremendous economic hardship on the rental industry—and more importantly--would significantly add to the cost of rental housing which ultimately results in higher rents. Or, requiring that all properties be made permanently lead safe before being made available for rent would significantly reduce the availability of all housing by discouraging investment in rental housing.

In lieu of economically debilitating and punitive laws, we strongly recommend that the Commission look to the creation of opportunities that would enable rental property owners to make repairs and/or carry out abatement activities that will foster lead safe housing in an affordable housing market. Some specific recommendations are:

- Create State and local income tax credits for property owners that carry out lead abatement activities.
- Enable local governments to provide property tax credits (similar to those provided for in PA 198) for those lead abatement activities which result in an increased assessment. (Example: vinyl siding, window replacement, new roof, etc.)
- Increase the time allowed between property maintenance inspections mandated under the Housing Law of Michigan to reward property owners that carry out abatement activities. (The current time between inspections is three years, maximum.)
- Significantly decrease a property owner's exposure to liability once they find that their property has lead based paint hazards. (Many property owners forego risk assessments and refuse to carry out hazard remediation or abatement due to the potential increased exposure to frivolous lawsuits.)
- Demand that all local governments follow State Law and utilize the property maintenance code (International Property Maintenance Code) as promulgated under the Single State Construction Code to ensure uniform property maintenance across the State.

Other recommendations include:

- Requiring all child care facilities and schools (licensed and unlicensed) be required to meet standards for property maintenance and lead hazards.
- Forbidding the sale of "no-iron baby formula".

We also encourage the Commission to support greater funding for lead poisoning educational activities. Some specific suggestions include:

- Requiring all schools to provide lead poisoning education as part of their curriculum;
- Requiring that information on lead poisoning and its prevention be provided to new parents.

In closing, we want to once again thank you for this opportunity to express our industry's views. I would be happy to answer any questions that you may have.

Get the Lead Out!

Preventing Childhood Lead Poisoning Through Partnership

Get the Lead Out! partners:

ADVOCACY COALITION FOR YOUNG CHILDREN & THEIR FAMILIES

AQUINAS COLLEGE, COMMUNITY LEADERSHIP INSTITUTE

BAXTER NEIGHBORHOOD ASSOCIATION

BAXTER COMMUNITY CENTER

CALVIN COLLEGE, DEPARTMENT OF NURSING

CALVIN COLLEGE, OFFICE OF COMMUNITY ENGAGEMENT

CHILD & FAMILY RESOURCE COUNCIL

CITY OF GRAND RAPIDS, HOUSING REHABILITATION OFFICE

CITY OF GRAND RAPIDS, OFFICE OF CHILDREN, YOUTH & FAMILIES

COMMUNITY REBUILDERS

DEVOS CHILDREN'S HOSPITAL

GRAND RAPIDS PUBLIC SCHOOLS

GRAND VALLEY STATE UNIVERSITY, KIRKHOF SCHOOL OF NURSING

HOME REPAIR SERVICES OF KENT COUNTY

JUNIOR LEAGUE OF GRAND RAPIDS

KENT COUNTY EARLY CHILDHOOD SYSTEM

KENT COUNTY HEALTH DEPARTMENT

KENT REGIONAL COORDINATED CHILD CARE

LIGHTHOUSE COMMUNITIES

MICHIGAN FAMILY RESOURCES, HEAD START

RENTAL PROPERTY OWNERS' ASSOCIATION

STRONG BEGINNINGS

Testimony to the Childhood Lead Poisoning Prevention and Control Commission

August 2, 2005

Good morning. My name is Paul Haan, and I am the Project Coordinator for the Grand Rapids-based *Get the Lead Out!* collaborative.

Get the Lead Out! is a 22 member collaborative formed in the year 2000. Our vision is to end childhood lead poisoning in Kent County, Michigan. To our great pleasure, we know that this is a goal that we can reach, with your help, in the coming decade.

Grand Rapids is Michigan's second largest city and was noted by the *Detroit Free Press* as having some of the city blocks with the highest concentration of identified childhood lead poisoning cases in the State of Michigan (July 29, 2003). Yet through concerted coalition building, Kent County has both increased testing rates by 28% in the past five years (from 8,697 children tested in 1999 to 11,112 children tested in 2004) and decreased the incidence of blood lead levels exceeding 10µg/dL (venous) by 61% (from 6.1% of children tested in 1999 to 2.4% of children tested in 2004). Coalition building has enabled Kent County to leverage $6.3 million towards this effort since 2001, the vast majority of these resources are non-state dollars (private philanthropy and federal funds).

We believe that local coalition building is paramount to solving this problem. If doctors, housing providers, parents, or anyone else could have fixed this problem alone, we would not continue to see thousands of the State's children poisoned each year. We need coalitions, working together on the local level, to get this work done.

c/o Community Leadership Institute at Aquinas College, 1607 Robinson Road SE, Grand Rapids, Michigan 49506
Phone: 616.241.3300 GTLO@sbcglobal.net Fax: 616.247.9556

Likewise, State policy and investment must support effective local action. Communication must be exceptionally open. Local coalitions must be involved in work groups that shape state policy. Where local philanthropy is unwilling, the State should consider seed funding and technical support for emerging local coalitions. Only by supporting the work of local partners will the State resolve this nearly monolithic problem.

Get the Lead Out! joins the Michigan Lead Safe Partnership in advocating for five of the six MLSP proposed action steps.

Immediate Action

1. The Michigan Legislature must restore the $500,000 in funding cuts for childhood lead poisoning prevention being called for in the Senate budget for the Department of Community Health (DCH).

2. The Michigan Legislature must restore full funding for the Michigan Childhood Immunization Registry (MCIR) and keep this important tool under the management of the DCH.

Short Term Action

3. Pass legislation allowing for the integration of childhood lead poisoning blood lead testing activity and results into the MCIR database. With a simple legislative amendment, Michigan could be the first state in the union to have an integrated electronic registry for childhood lead poisoning surveillance. Linking lead to the MCIR is an effective tool that is being demanded by doctors, HMOs, public health, communities, parents and children. The legislature should immediately approve appropriations sufficient to make this change effective by the end of 2005 (estimated at $200,000).

Long Term Action

4. Create a Public Health Trust Fund as called for in the November 2004 Task Force Report. This Trust Fund should be created by 2006. A minimum of several million dollars in deposits (not necessarily state budget appropriations) earmarked for childhood lead poisoning prevention should be secured by 2007. Funding mechanisms to supply ongoing revenue for childhood lead poisoning prevention must be instituted by 2007—mechanisms such as fees on the sale of paint and other surface coating materials, capture of criminal and civil fines, and other creative ways of generating dedicated revenue.

5. Michigan must build upon the 2004 legislation creating a statewide Lead-Safe Housing Registry by enacting legislation to make the Lead Safe House Registry mandatory for all rental property by 2012. Michigan should take a reasoned, graduated approach, beginning in 2006, that allows rental property owners adequate time to bring their entire portfolio of pre-1978 housing into compliance. Michigan should join other states (Oregon, Maryland) in providing rental property owners who comply with liability protection. State and Federal resources for tenant-based rental assistance can be linked to compliance with the registry. Rep. Kooiman's bills for proposed tax credit for lead hazard control (HB 4408, HB 4409) should be further developed and passed as an incentive for compliance and protecting children.

Get the Lead Out! will continue to work on this problem at the local level in Grand Rapids. Yet local action must be linked to statewide change for solutions to be long lasting. To that end, we commit ourselves to working with the Childhood Lead Poisoning Prevention and Control Commission.

Please contact our Project Coordinator, Paul Haan at (616) 241-3300 or *GTLO@sbcglobal.net* so that we may continue to be an active partner in solving this local and statewide problem. We applaud and fully support your efforts to protect Michigan's children from this 100% preventable problem.

Paul Haan
Get the Lead Out!
"Preventing Childhood Lead Poisoning through Partnership"

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# # #

DeVos Children's Hospital

Testimony to the
Childhood Lead Poisoning Prevention and Control Commission
August 2, 2005

Thank you for the opportunity to come before you this morning. My name is Maria Cruz, and I am the Program Coordinator of the PANC program at Spectrum Health Healthier Communities. Spectrum Health's children's hospital, DeVos Children's Hospital (DVCH), is a member of the Get the Lead Out! collaborative. Dr. Jeri Weyher is the medical director of DeVos Children's Hospital's Lead Clinic which is the longest operating lead clinic in Michigan.

DeVos Children's Hospital is very willing and eager to work with the Commission to fulfill the charge you received from the governor. Specifically, we hope to advance your efforts on the following action steps which we believe will support medical care providers enabling them to prevent and treat lead poisoning in pregnant woman and children. These action steps are adding lead testing results to the Michigan Childhood Immunization Registry (MCIR) and the creation of the Lead Safe House Registry.

- We encourage the commission to introduce legislation allowing for the integration of childhood lead poisoning blood lead testing activity and results into the Michigan Childhood Immunization Registry(MCIR). The $200,000 appropriations needed to make this change effective by the end of 2005 must also be provided.
    - Including the results of lead testing in the MCIR would eliminate costly retesting of children for lead levels. Frequently children have had their lead tested at the WIC program or another community clinic. However, when they come to a routine appointment with their health care provider that information is not available. In order to provide appropriate treatment, the physician must have the blood test drawn again, possibly delaying treatment and subjecting the child to an uncomfortable procedure.
    - (Experience of PANC clients)

- We also encourage the commission to build upon the 2004 legislations creating a statewide Lead-Safe Housing Registry by enacting legislation to make the Lead Safe Housing Registry mandatory for all rental property by 2012.
    - Treating lead poisoning can almost always be done on an outpatient basis. However, there are times when physicians admit children for treatment to ensure they are in a safe environment. Treating lead poisoning is ineffective if the child is still in a lead poisoned environment. A Lead Safe Housing Registry would allow physicians to check the status of a poisoned child's house and make appropriate treatment decisions.

- (Experience of PANC clients)

Thank you, again, for the opportunity to testify before this committee. We are encouraged by the creation of the Commission and look forward to working with you to end childhood lead poisoning.

I'd be happy to answer any questions. Otherwise, if we can be of additional support, please do not hesitate to contact us.

Dr. Jeri Weyher
Jeri.Weyher@spectrum-health.org

Maria Cruz
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Prepared and Given By:
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Since its beginning, Michigan State University Extension has focused on bringing knowledge-based educational programs to the people of the state to improve their lives and communities. Today, county-based staff members, in concert with on-campus faculty members, serve every county with programming focused on agriculture and natural resources; children, youth and families; and community and economic development.

Michigan State University Extension believes that children, youth, and families interact in intricate patterns and face equally intricate challenges. People are deeply affected by their environment, significant others, and their communities. Lead is an issue that affects all families in Michigan. MSU Extension is committed to continuing to educate families about the dangers of lead. To address this issue an environmental hazards curriculum called Home Safe Kids was created. It is used by Extension staff to educate parents on the issues of radon, lead, secondhand smoke and mold. Currently, there are 17 counties piloting and evaluating Home Safe Kids. This curriculum is being used in conjunction with MSU Extension programs in parenting, day care, and nutrition. Extension is committed to providing families in Michigan with research-based information on the topic of lead and lead poisoning prevention.

MSU Extension is committed to continue to foster relationships with other organizations that work in the area of lead poisoning prevention. Many more collaborations need to be developed to help the families of Michigan find the best resources available to them. Extension commends the work of the commission and will continue to support the efforts the commission and other organizations are making in the area of lead poisoning prevention and education.

FNI

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Testimony of Field Neurosciences Institute Before The Childhood Lead Poisoning Prevention and Control Commission
August 2, 2005

Good morning. My name is Ken Santa and I represent Field Neurosciences Institute which is based in Saginaw. Field Neurosciences Institute is a non-profit, charitable, educational and scientific organization which is affiliated with St. Mary's of Michigan. The mission of FNI is based on the pillars of prevention, early diagnosis, care and cure of neurological diseases, disorders and injuries. Prevention programs are the key components of the mission of FNI. These programs are aimed at the community and are designed to help people practice the most effective form of medicine...that, of course, is prevention.

Based on 2002 blood lead levels tested in children six years old and younger, Saginaw County ranks in the top 25% of all counties in Michigan for elevated levels of lead. 29% of the housing in Saginaw was built pre-1950, which is a predeterminer of exposure to lead. As you know, the risk of lead poisoning is greatest in children under the age of six. Children with lead poisoning show poorer performance on tests of arithmetic skills, reading skills, non-verbal reasoning and short-term memory. Early lead exposure is associated with a sevenfold increase in the risk of failing to graduate from high school and a six-fold increase in reading disabilities.

To try and make a dent in this problem, FNI participates in a childhood lead poisoning testing program together with the Michigan Department of Community Health. FNI tests the child's lead level by performing a finger stick. The blood sample is sent to MDCH in Lansing. FNI reports the child's test results and recommends an appropriate follow up examination, consultation, and environmental evaluation. We have discovered that roughly one child in ten tests high for lead in our region. This is all done at absolutely no charge. FNI also conducts educational workshops for homeowners and landlords to explain the problem and to teach them how homes can be made lead-safe. This too is done at no charge because this work is part of the mission of FNI.

Recently, FNI has been enlisted to help fulfill a grant to the Saginaw County Health Department for the creation of a Saginaw Lead Hazard Control Program. But due to the threat of liability, the hospital we are affiliated with, St. Mary's of Michigan, has mandated we obtain liability coverage for lead, which is only sensible and prudent. The main insurance carrier for the hospital, a national company out of St. Louis, Missouri, tried for weeks to obtain coverage for us, but failed. They were not able to find a carrier for this kind of "specialty coverage." We were told that if we could find it, the price would probably make it prohibitive for us to purchase. As a result, we are forced to scale

FNI

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back our plans to participate in the Saginaw Lead Hazard Control Program. We will still be involved, but most of our involvement will be on an educational level only. We are beginning to wonder if we might have to halt our Lead Program work entirely, due to the threat of lawsuits and the cost and availability of liability insurance. We enjoy our relationship with the Michigan Department of Community Health and want it to continue. To that extent, I urge the Commission to look into this matter and hopefully, become involved in a solution. Thank you for allowing our input and we look forward to a long and productive relationship.

Michigan Childhood Lead Poisoning Prevention and Control Commission

Public Hearing--August 2, 2005
Michigan Library and Historic Center
Lansing, Michigan

(Testimony of Julie Griffith, Director of Quality Improvement, Physicians Health Plan of Mid-Michigan)

Good Morning. My name is Julie Griffith and I am Director of Quality Improvement for Physician's Health Plan of Mid Michigan. I am here today testifying on behalf of both PHP-MM and the Michigan Association of Health Plans – which PHPMM is a member.

Overview

We are pleased to be able to participate in this hearing and congratulate the Commission for holding this first hearing to receive public comment and testimony. The formation of the Commission is a result of Public Act 431 of 2005. The Michigan Association of Health Plans and its members were pleased to not only be part of the State Task Force, under the leadership of our Surgeon General, Dr. Wisdom that developed the Strategic Plan for Blood Lead prevention and control but also to assist in the development of the various pieces of legislation necessary to implement the Task Force's recommendations. The Task Force Recommendation on Blood Lead Screening levels to be administered by Medicaid Health Plans establishes ambitious but achievable objectives by the year 2007 for our industry.

While we are very aware that there are many facets to the prevention and control of childhood blood lead poisoning, our focus as an industry is targeted on reaching as many children as possible and conducting appropriate screening tests to assess whether the child is at risk for lead poisoning. As you may know, this issue goes beyond the Medicaid program and potentially affects all children. Therefore, our programs are established to be as broad based as possible.

Medicaid Health Plan Objective

However, much of the focus is on Medicaid children and more than 500,000 Medicaid adolescents are enrolled in the Medicaid Managed Care program. Physicians Health Plan is one of the 15 contracted health plans with the State of

Michigan and is working collaboratively with community agencies to address the objective of increasing childhood screening rates. All Medicaid enrolled children are considered to be at high risk for blood lead poisoning. In accordance with the Centers for Medicare and Medicaid Services guidelines, Michigan Medicaid policy requires that all Medicaid enrolled children be blood lead tested at 12 and 24 months of age, or between 36 and 72 months of age if not previously tested.

The legislative mandate (Public Act 55 of 2004) to have Medicaid Fee-for Service and Managed Care Plans increase screening levels to 80% by 2007 is in place and members of MAHP along with the Department of Community Health have establish annual appropriate targets to move everyone toward the overall objective. MDCH has designed a report, **Medicaid Blood Lead Testing**, to monitor compliance with this law. The report provides monthly blood lead testing rates for managed care enrolled children, fee-for-service children, and CSHCS/Medicaid dual enrolled children. County specific data are also provided. The report focuses on testing levels for two and three year old children, as well as all children between one and six years old.

By all reporting results, movement has been significant. The overall industry screening rate has moved from about 48% of children before receiving at least one blood lead test before their 3rd birthday in April of 2004 to nearly 60% in July 2005. As you know, this monthly report is made available on the MDCH website and is provided electronically to health plans to monitor progress toward achieving this objective.

Not in My Back Yard

How have PHPMM and other health plans improved their screening rates? By hard work, collaboration with community agencies and information and communication with our health care providers. I would like to illustrate this point with the most recent initiative taking place right here in the region around the Capitol. Our project is entitled, "Not in My Back Yard".

The childhood lead poisoning screening rate continues to be extremely low in Ingham County. Recently the Michigan Department of Community Health released a map of Ingham County that identified the location of children 0-6 years old and their testing status. It showed that many children who hadn't been tested were living right around Sparrow Hospital, Ingham Regional Hospital, and the MDCH Public Health Complex. Several who were tested had elevated levels. The threat of lead

poisoning was right in our back yard! This revelation inspired the "Not In My Back Yard" project, with the goal of getting all of these children tested for lead poisoning.

The project is a partnership with Physicians Health Plan of Mid-Michigan, Sparrow Regional Labs, McLaren Health Plan, Lansing Board of Water and Light, MDCH, Ingham county Health Department, BCBS, and McDonald's.

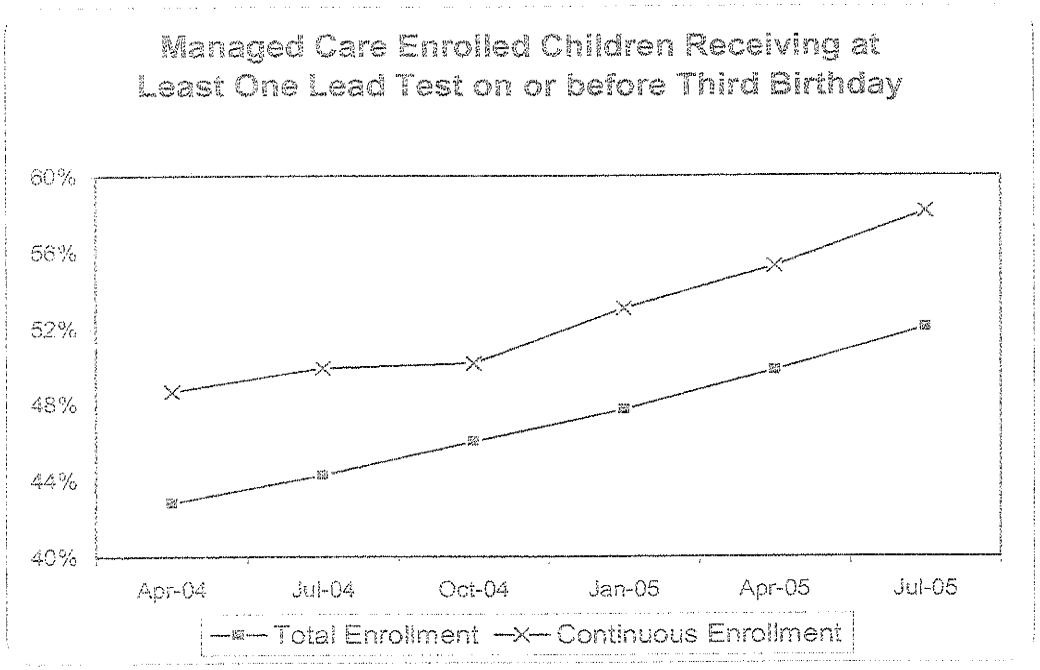
Dignitaries from the State and executives from the partners were present at a kick-off press conference. On June 10th, teams of people from PHPMM-FC, McLaren, MDCH Ingham County HD, and BWL went door to door in the neighborhoods surrounding the hospitals, promoting the event and leaving informational door hangers announcing the event a week ahead of testing. Between the two health plans- (PHPMM and McLaren Health Plan), more than 4,000 flyers were distributed. Two weeks later the Board of Water and Light meter readers distributed 2,000 more in North Lansing for a total of 6,000. The public was invited to select Sparrow and Ingham Regional Laboratory Patient Centers where there was an open physician order for testing. The target age for testing was children under six years of age. Those who were tested received a $10 McDonald's gift certificate in the mail. McDonald also promoted the event in their Lansing area restaurants with posters and take-out bag inserts.

Results

138 children have been tested as a result: 104 from the Medicaid Health Plans, 12 covered under commercial carriers, 10 BCBS, and 12 uninsured. One child was found with an elevated blood lead level needing medical intervention.

Summary and Recommendation

Medicaid Health Plans are moving their screening rates in the right direction and should reach the legislative objective by 2007. Each Health plan will have a different strategy due to their community and provider panel. However, even if we reach our target, unless the presence of lead is removed, we have not fully protected children from lead poisoning. Once tested and assess for blood lead, children return to the same environment. We therefore encourage the Commission to focus energy and attention to the over-riding need of elimininating lead from our environment. Thank you for this opportunity to present the comments representing the Michigan Association of Health Plans and Physicians Health Plan of Mid Michigan Family Care.



- Total Enrollment
  - -Enrolled in measurement month
- Continuous Enrollment
  - -Based on MMIS eligibility system
  - -Enrolled in same health plan for the measurement month and 12 months preceding 3rd birthday, with a 1-month allowable gap.

Table 7. Blood Lead Testing of Three Year Old Children by Length of Enrollment

July 2005

Health Plan Name	Total Enrollment			Continuous Enrollment			
	Eligibles	Eligibles with at least one lead test on or before 3rd birthday	Percent of Eligibles with at least one lead test on or before 3rd birthday	Eligibles	Eligibles with at least one lead test on or before 3rd birthday	Percent of Eligibles with at least one lead test on or before 3rd birthday	Percentage Point Difference with Continuous Enrollment
CAPE Health Plan	4,119	2,269	55%	2,099	1,312	63%	7
Community Choice Michigan	1,984	1,015	51%	1,163	726	62%	11
Great Lakes Health Plan, Inc.	4,380	2,010	46%	2,319	1,171	50%	5
Health Plan Of Michigan, Inc.	4,112	2,038	50%	1,907	1,145	60%	10
HealthPlus Partners, Inc.	2,712	1,275	47%	1,663	857	52%	5
M-Card	862	331	38%	447	217	49%	10
McLaren Health Plan	2,152	743	35%	848	334	39%	5
Midwest Health Plan	2,389	1,462	61%	1,239	881	71%	10
Molina Healthcare of Michigan	5,786	3,204	55%	2,059	1,070	52%	-3
OmniCare Health Plan	2,005	1,348	67%	1,159	812	70%	3
PHP-MM Family Care	885	387	44%	456	228	50%	6
PHP of Southwest Michigan	1,627	785	48%	950	548	58%	9
Priority Health Government Programs, Inc.	1,908	1,192	62%	894	645	72%	10
Total Health Care	1,882	1,111	59%	1,010	667	66%	7
Upper Peninsula Health Plan	1,026	515	50%	654	358	55%	5
Managed Care Totals/Percent	37,829	19,685	52%	18,867	10,971	58%	6
Current Performance Monitoring Standard			45%			50%	
FFS (Title XIX only)	8,429	3,239	38%	2,752	1,029	37%	-1
FFS (Title V/XIX)	1,043	543	52%	694	331	48%	-4
FFS Totals (Title XIX and V/XIX)	9,472	3,782	40%	3,446	1,360	39%	0

Total Enrollment:

- Based on MMIS eligibility system
- Enrolled in plan (health plan or FFS) for the measurement month

Continuous Enrollment:

- Based on MMIS eligibility system
- Enrolled in same plan (health plan or FFS) for the measurement month and 12 months preceding 3rd birthday, with 1-month allowable gap

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August 2, 2005

Dr. Kimberlydawn Wisdom, Chairperson
Childhood Lead Poisoning Prevention and Control Commission
C/o Health Management Associates
120 North Washington Square, Suite 705
Lansing, MI 48933

CHILDHOOD LEAD POISONING PREVENTION AND CONTROL COMMISSION PUBLIC HEARING TESTIMONY

The problem of child lead poisoning from lead based paint is pervasive. Despite the recent progressive action taken by the state, local municipalities, community organizations and other interested stakeholders, child lead poisoning still ravishes our communities. The result is a significant number of lead poisoned children, that our current system of medical coverage and educational supports are ill equipped to address.

The Michigan Department of Community Health (MDCH) has identified thirteen (13) targeted communities in which older pre-1978 housing is common place and the incidence of lead poisoning for children under the age of six (6) is extremely high. It is mandatory to bear in mind that each child lead poisoned is an individual life relegated to a future of disability through physical, cognitive, and psychological deficits. Based upon MDCH data, the identified thirteen (13) targeted communities in 2003, confirmed 15,706 children under the age of six (6) with elevated blood lead levels (EBLL), and in 2004, 16,154 children under the age of six (6) were confirmed with EBLLs. In just this two-year period within the targeted communities, a total of 31,860 children under the age of six (6) may never achieve their full potential and success because of child lead poisoning. This number is higher than the casualties and wounded American soldiers in the war in Iraq. **This should be a startling fact.** In the last two years we have lost over 30,000 lives to the devastation of child lead poisoning. Lives that may change from a future of positive contribution to our society to lives that may become a financial and social burden on society. As trial attorney, I had the opportunity to see the devastation

of young lives as a result of child lead poisoning. The protection of the innocent is our responsibility.

The current efforts set forth by the state, municipalities, community groups and other interested stakeholders have been significant and is commendable. But we must do more. We must also channel our efforts to specific areas that will have immediate as well as long term impact. There are three specific areas that warrant immediate attention for the continued progress in the quest to eliminate child lead poisoning.

The first area pertains to the newly enacted Administrative Rules governing lead hazard control activities. The Michigan Department of Community Health ("MDCH") by and through the statutory authority conferred on it promulgated Administrative Rules 325.99101-325.99408, entitled, Lead Hazard Control. These rules set forth specific training, certification and work practice standards that must be followed in the performance of all lead hazard control work. Unfortunately, Administrative Rule 325.99406 ("R406"), entitled, Lead Hazard Control Activities does not differentiate the specific types of non abatement lead hazard activities and places an undue burden on parties performing procedures involving lower risks and less complex techniques such as technical cleaning. It is ironic, there is not a clarification for the various non-abatement activities with corresponding guidelines based upon the scope and complexity of the work. In R406, it clearly provides:

> Rule 406(1). Only an individual who has successfully completed **either** of the following training courses shall conduct non-abatement lead hazard control activities:
>
> (a) **A lead-safe work practices training course approved by HUD.**
> (b) An accredited lead abatement worker course. (emphasis added)

The clear interpretation of R406(1)(a) indicates a individual who successfully completes a EPA and HUD approved lead safe practice training course is qualified to conduct non-abatement lead hazard control activities. However, the stringent language set forth in R406(4), actually nullifies or at minimum diminishes the capacity of an individual trained in accordance with R406(1)(a) to perform non-abatement work. R406(4) provides in relevant part:

> Rule 406(4). "...The certified supervisor shall be at the site during all lead abatement activities, and **during all set-up and cleaning activities for non-abatement lead hazard control work.**" (emphasis added).

The language in R406(4) requires parties to retain and have a certified supervisor on site during set-up and the performance of cleaning activities.

The excessive costs and undue burden placed upon parties renders them unable to carry out the salient task of providing primary intervention services until more permanent abatement activities can be performed at high risk housing. With EPA and HUD guideline trained workers performing the technical cleaning tasks, it is unnecessary for a certified supervisor to be present on site during set-up and cleaning activities. Obviously, a certified lead inspector or risk inspector would be mandatory for the initial inspection of dwellings to accurately reflect the specific areas to be cleaned. But mandating a certified supervisor to be on site during set-up and cleaning is excessive and undercuts the tremendous benefits that are being receive by the community through technical cleaning to high-risk populations. Many property owners are now exhibiting responsible behavior by becoming trained in HUD and EPA approved lead safe work practices. The imposition of the cumbersome and costly requirement of a certified supervisor for set-up and cleaning activities will deter the much needed participation of the property owners in the crucial primary intervention process for high risk housing. R406 should be rescinded and rewritten to reduce the undue burden on individuals attempting to reduce lead risks to children.

The second area relates to education and awareness. The current education and awareness programming largely focuses on the child interest stakeholders, which is extremely important. However, to effectively eliminate child lead poisoning the **risk** must be eliminated, which, are in the control of the property stakeholders. A concerted effort must be made to educate property owners in a manner that not only relates the adverse of effect of lead on children, but also outlines the benefits that accrue to them by maintaining lead safe housing. Property owners must have access to the technical assistance and support that promotes the ideals of lead safe housing as a necessary risk management and loss prevention technique. Additionally, property owners must be educated not only to their responsibilities and obligations under the law, but also of the potential benefits received by maintaining their property lead free. This is a salient educational component that must be implemented to achieve the goal of eliminating the risk of lead in housing.

The final area addresses the issue of funding. It is common knowledge that public resources targeted for child lead poisoning in Michigan is limited. Yet, to adequately address the problem of child lead poisoning a strong continual stream of funding is necessary. To fill this funding gap, creative incentives to private corporations to adopt or take on certain levels of financial responsibility for targeted communities may be an option to increase current funding levels. Additionally, incentives for property owners who are willing to be proactive in eliminating

lead in rental housing can help offset some of the costs property owners will incur making their properties lead safe. Incentives for property owners also create a balance to more stringent legal consequences for not maintaining lead safe housing.

The goal of eliminating child lead poisoning is one that can only be reached through cooperative efforts of all stakeholders, both child interest stakeholders and property interest stakeholders. However, if we can reconcile the interests of all stakeholders to work toward this common goal, we can eliminate child lead poisoning and ensure bright futures for the children living in our communities.

Respectfully submitted,

Vanessa G. Fluker, MA, JD

August 10, 2005

Dr. Kimberlydawn Wisdom; Chairperson
Childhood Lead Poisoning Prevention and Control Commission
Department of Community Health
3423 North Martin Luther King Jr. Boulevard
P.O. Box 30195
Lansing, Michigan 48909

Re: Testimony to the Childhood Lead Poisoning Prevention and Control Commission

Dear Dr. Wisdom and Members of the Commission:

Thank you for your service to the children of the State of Michigan and your work on this important Commission. By solving the problem of childhood lead poisoning, we can save the State of Michigan and local communities significant dollars that are now used to address preventable problems such as health disparities, remedial education, deteriorated housing, law enforcement and corrections, and under- and unemployment. An investment in childhood lead poisoning prevention will help assure that all of our children grow up healthy and reach their fullest potential.

I send my regrets for not being able to attend the August 2, 2005 Public Hearing of the Childhood Lead Poisoning Prevention and Control Commission and am thus providing this written testimony.

The City of Grand Rapids has long recognized that an investment in prevention today will save us future expenses. To that end, the City has invested in local strategies to end childhood lead poisoning. In the year 2000, the City adopted a policy that all lead hazards will be addressed in any housing unit receiving assistance through our Housing Rehabilitation Office. Through this program, the property owner is responsible for all rehabilitation costs and the City picks up the tab for any additional lead hazard control work that is not addressed by rehabilitation activities. In addition, the City has been an active and funding partner of the *Get the Lead Out!* coalition.

The State of Michigan must position itself to be an ongoing partner in addressing childhood lead poisoning. To do so, the State must create a funding stream to address statewide costs associated with eliminating childhood lead poisoning. One mechanism identified by the *Governor's Task Force to Eliminate Childhood Lead Poisoning* is the creation of a Public Health Trust Fund.

As the Mayor of the second largest City in the State of Michigan, I respectfully request that the Commission provide the leadership necessary to ensure that the State creates and funds the Public Health Trust Fund. More specifically, I request that the Commission ensure that the elimination of childhood lead poisoning be addressed through the creation of restricted fund within the Public Health Trust, and that this restricted fund be provided adequate funding resources.

The Public Health Trust Fund should be created by 2006. A minimum of several million dollars in deposits should be earmarked for childhood lead poisoning prevention by 2007. Funding mechanisms to supply ongoing revenue for childhood lead poisoning prevention should be instituted by 2007. These mechanisms might include a state fees on the sale of paint and other surface coating materials, capture of criminal and civil fines, and other creative ways of generating dedicated revenue.

Both the State of Michigan and local municipalities are challenged in this time of declining revenues. Yet we can still institute creative opportunities to address our communities' most pressing needs. The creation of a Public Health Trust, modeled after the existing trust in the State of California, is one such opportunity. The model exists and the need is great, thus I pledge my support to the Commission as it advocates for such a resource.

If I can be of further help, or can clarify the priorities of local communities that are engaged in the elimination of childhood lead poisoning, please feel free to contact me at (616) 456-3168 or *mayor@ci.grand-rapids.mi.us.*

You have my wholehearted support and best wishes for great success in your efforts to eliminate childhood lead poisoning in the State of Michigan.

Sincerely,

George K. Heartwell
Mayor

MONROE COUNTY HEALTH DEPARTMENT
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Rebecca A. Head, PhD, DABT
Health Officer/Director

8/8/05

Written Testimony for The Childhood Lead Poisoning Prevention and Control Commission

Governor Granholm's July 2003 release of **"Childhood Lead Poisoning Prevention: A Call to Action"** initiated lead poisoning prevention becoming a **top priority in Michigan.** Childhood lead poisoning prevention has gained media attention, raising awareness among parents and health professionals about the dangers of this preventable disease. Lead testing rates have improved, but continue to fall short of the requirement that all children, at ages 12 and 24 months, who are on Medicaid, be tested for lead levels. Michigan July 2005 test data showed that **only 45%** of enrollees received initial lead tests **before their second birthdays,** and 50% received one test before their third birthday.

Note that situations include the following.

1. Children, who receive well child exams around their first and second birthdays, are often not provided lead blood level testing.
2. In many cases, the physician's office will give the parent a laboratory order to have the lead test done elsewhere, but the parent fails to follow-up.
3. In some cases, parents indicate that they would have the lead test done but they do not know where to go for off-site testing, and are not given proper direction from their physicians.
4. Many physicians test the Medicaid population, but fail to recognize the importance of screening all children for lead poisoning, and testing where appropriate.

Recommendations that can assist in resolving these barriers and increasing lead testing rates are:

1. Increased State of Michigan **incentives and assistance** that encourage physicians to perform **on-site** lead testing;
2. Managed care organization provision of accessible, clear **information** to parents and physicians about appropriate testing laboratories (i.e., laboratories within the system) to promote more testing;
3. **Mandatory physician/nurse education** to aid in professionals recognizing the need for screening all children populations for lead poisoning; and
4. **Increased sanctions** and/or penalties against physicians who do not comply with state mandated protocols for testing children on Medicaid.

Increasing lead testing is important. Enhancing **public awareness** so to prevent childhood lead poisoning is also critical. Parents and caregivers of children living in designated high-risk areas should have easy access to such information. **Dissemination of educational materials** could occur via slide shows and other materials at block parties, to Neighborhood Watch groups or in places of worship. **Children identified as having some level of exposure** through lead testing, but not considered lead poisoned, **must be monitored.**

Primary Prevention is the focus of the Childhood Lead Poisoning Prevention Program and key to that prevention is educating the parent/caregiver of risks before long term health, behavioral and

developmental problems occur. Local public health departments (LPHDs) are struggling to undertake this role by sending mailers, providing door to door education in high-risk areas and via other means. Prevention is the goal in public health education and resources are necessary for childhood lead poisoning prevention to become a reality. Very few LPHDs receive any type of funding for lead prevention. Michigan LPHDs representatives, asked in a recent survey regarding what could be done to improve support of local activities, overwhelming responded that **program support funding is essential**.

Respectfully submitted by:

Rebecca A Head, PhD, DABT/Monroe County Health Officer
Janice Schnorberger, RN, BAS/Monroe County Lead Prevention Nurse

Michigan Head Start Association, Inc.

AUG 0 4 2005

August 2, 2005

To: Childhood Lead Poisoning Prevention and Control Commission

From: Richard Lower, Executive Director

Re: Childhood Lead Poisoning and Prevention in Michigan

Dear Members of the Childhood Lead Poisoning and Control Commission:

On behalf of the Michigan Head Start Association (MHSA), I thank you for the opportunity to share our thoughts with you regarding childhood lead poisoning and prevention in Michigan.

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Head Start is a federally funded program for children birth to age five and their families. It was launched in 1965 to help break the cycle of poverty by providing preschool children of low-income families with a comprehensive program to meet their educational, emotional, social, health, and nutritional needs. There are currently over 35,000 children and their families being served in Michigan's 83 counties.

Exposure to lead poisoning is of significant concern to the Head Start community. Many Head Start families live in older homes and live in neglected communities, thus making them more at risk to the exposure of lead elements. Furthermore, many Head Start families lack access to resources such as internet usage and other materials that can educate them about the dangers of lead in their homes. Therefore, MHSA finds it critical that Head Start children and their families have access to resources and materials that will ensure their safety. Moreover, good public policy needs to be in place to decrease their exposure to the dangers of lead.

The research is conclusive and has proven that the costs associated with preventing childhood lead poisoning provide an overwhelming cost-benefit to those who invest in prevention related to long term physical health. Yet there is more to the equation than medical costs alone. We know that childhood lead poisoning has an adverse impact upon cognitive development which in turn impacts a child's ability to succeed in school and in life.

Investment in simple changes to housing policy has immediate realized economic returns by preventing poisonings. Whether it's a Head Start child or another child living in poverty, lead poisoning will adversely effect the education of many 1000's of Michigan children and has implications for Michigan's economy and workforce.

On behalf of all Head Start families in Michigan, and as a member of the Michigan Lead Safe Partnership, I urge you to take action in the following areas related to childhood lead poisoning in Michigan:

RESTORATION OF PREVENTATIVE FUNDING

- Call upon the Michigan Legislature to restore the $500,000 in funding cuts to childhood lead poisoning prevention being called for in the Senate FY 2006 budget for the Department of Community Health (DCH).
- Call upon the Michigan Legislature to restore full funding for the Michigan Childhood Immunization Registry (MCIR) and keep this vital tool under the management of the DCH.

MCIR DATABASE AND EPSDT SCREENING

- Pass legislation allowing for the integration of childhood lead poisoning blood lead testing activity and results into the MCIR database. Provide appropriations sufficient to make this change effective by the end of 2005 (estimated $200,000).
- Strengthen the testing and follow-up requirements through improved legislation and/or rule making. Make it clear to providers which populations are subject to screening under EPSDT. These populations should include Medicaid and all children residing in the thirteen high-risk communities as identified by DCH, as well as all children living in high-risk zip codes. Limit incentives to those providers who do not comply with these requirements.

LEAD-SAFE HOUSE REGISTRY

- Build upon the 2004 legislation creating a statewide Lead-Safe Housing Registry by enacting legislation to make the Lead-Safe House Registry mandatory for all rental property by 2012. Take a reasoned, graduated approach, beginning in 2006, that allows rental property owners adequate time to bring their entire portfolio of pre-1978 housing into compliance.

On behalf of the Head Start community, thank you for the invitation to give input on this important issue. Please feel free to contact me at 517-374-6472 or by email at Richard@mhsa.ws.

AUG 07 2005

Voices for Michigan's Children
Speaking Up for Kids

August 2, 2005

MEMORANDUM

TO: Childhood Lead Poisoning Prevention and Control Commission

FROM: Sharon Claytor Peters, President and CEO

SUBJECT: Addressing Disparities

I appreciate this opportunity to share with the Commission the concerns of Michigan's Children related to lead poisoning prevention. Michigan's Children has focused much of its energy on addressing racial and ethnic disparities in outcomes for children, with an eye on early childhood and school readiness. The brain science is very clear. Children's experiences and exposures early in life have lifelong effects, and lead poisoning is one negative exposure that it is entirely preventable.

Children of color are more likely to be exposed to lead, in large part because of racial stratification in access to housing. While Michigan has been making steady progress in lead testing and prevention, more needs to done to focus on African American children who have the highest rates of lead poisoning. National data show that 60 percent of all one- to five-year-old children with confirmed elevated blood lead levels between 1997 and 2001 were African American. These children enter school with clear deficits, including potentially lower I.Q.'s, higher incidences of hyperactivity and other neurological problems, and potential vision and hearing losses.

Michigan's Children has been pleased with the leadership shown by the State's Surgeon General, Kimberly Dawn Wisdom, in the area of lead poisoning prevention. In 2003, we supported the package of bills addressing lead poisoning prevention, including the bill establishing this Commission. Of particular importance in that package was Public Act 55 that requires that by October 1, 2007, the state's Medicaid providers must be in "substantial compliance" with federal guidelines requiring states to test all children enrolled in Medicaid for lead poisoning. Public Act 55 defines substantial compliance as a screening rate of 80 percent. If Medicaid providers do not reach that rate by the deadline set in statute, the Department of Community Health may use funds appropriated for the providers to contract with community agencies to provide the screening needed.

The evidence so far suggests that Medicaid providers are falling short in their lead testing efforts, and we recommend that community-based strategies not be delayed until 2007. Federal guidelines require testing at 12 and 24 months of age, and current quality assurance standards for Michigan health plans serving Medicaid-enrolled children track

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only whether a child has been tested at least once by two and three years of age. Even with that reduced standard, statewide less than half of three-year-old children enrolled in Medicaid have been tested. More encouraging are testing levels in the City of Detroit, where 71 percent of three-year-olds have been screened at least once.

As the commission proceeds with its work, we recommend the following:

- Document and address racial and ethnic disparities in the risk of lead poisoning, as well as access to testing and abatement services.
- Target prevention and abatement services on communities of color, assuring that outreach efforts address cultural and other barriers. This work can best be done if there is collaboration among health departments, community-based organizations and minority communities.
- Restore funding for outreach for Medicaid and MIChild, with a specific focus on underserved communities, including communities of color. Children without regular access to preventive care will not be appropriately screened for lead poisoning.
- Use the purchasing power of the state to ensure that health plans comply with federal requirements to screen all Medicaid-eligible children at 12 and 24 months of age. In the interim, immediately pursue contracts with community-based agencies in high-risk communities to perform lead screenings.

Thank you for this opportunity to address our concerns. We look forward to working with the Commission as it moves forward to eliminate lead poisoning

STATE OF MICHIGAN
DEPARTMENT OF ENVIRONMENTAL QUALITY
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

STEVEN E. CHESTER
DIRECTOR

August 12, 2005

Dr. Kimberlydawn Wisdom, MD, MS
Michigan Surgeon General
Chairperson, Childhood Lead Poisoning Prevention and Control Commission
c/o/ Health Management Associates
120 North Washington Square, Suite 705
Lansing, MI 48933

Dear Dr. Wisdom:

SUBJECT: Department of Environmental Quality Comments – Childhood Lead Poisoning Prevention in Michigan

Thank you for the opportunity to provide comments to the Childhood Lead Poisoning Prevention and Control Commission (Commission). The Department of Environmental Quality (DEQ) strongly supports the Commission's mission and looks forward to playing an important role in Michigan's efforts to address the public health and environmental challenges posed by lead. The DEQ has been an active participant in this effort from its inception, and based on its experiences to date, offers the following observations for the Commission's consideration.

The DEQ recognizes that lead exposures resulting from pollution originating outside the home are typically a small component of the overall lead exposure experienced by Michigan's children with lead paint exposure being primary. However, as was noted in the original Childhood Lead Poisoning Prevention Task Force report, lead contamination exists in the environment from a wide variety of historical and current sources and is very difficult to relate back to specific sites or activities. The ubiquitous nature of lead in urban industrial environments will continue to pose significant technical and policy challenges for the State of Michigan.

Nonetheless, the DEQ continues to make the identification, control and minimization of lead exposure a priority across all of its programs. The DEQ's inclusion of lead limits in a variety of discharge permits, ongoing environmental monitoring for lead in air and water, and the effort to identify and address specific sites of lead contamination are all examples of the DEQ's commitment. Through these efforts, the DEQ has learned that any significant effort to reduce lead exposure from environmental lead contamination will require substantial additional resources.

In particular, the DEQ's ongoing work to assess suspected lead smelter sites in the City of Detroit illustrates the challenges the DEQ faces. The DEQ has been evaluating

several sites where lead smelting activities were suspected to have occurred to determine if significant on- or off-site lead impacts have resulted from those operations. The DEQ had sought additional staff and project resources for this work in FY 2004, but did not receive approval, leaving the agency to rely on limited staff and project funding resources. To date, the DEQ has identified one area, referred to as the Grand Haven Street Area site, where historical lead smelting activities have resulted in lead levels in nearby residential soils at levels that exceed applicable cleanup criteria. The DEQ recently received an appropriation of $1.5 million in FY 2005 Clean Michigan Initiative funds for the Detroit Lead Smelter project. However, this funding will not cover the remedial costs for the Grand Haven Area Site (estimated to exceed $4 million), let alone needed investigations of eight remaining sites. The DEQ is currently working closely with the U.S. Environmental Protection Agency to determine whether federal funding can be provided to assist with the Grand Haven site. The DEQ's funding for environmental investigation and cleanup has now diminished to the point that further work at suspected smelter sites in Detroit may not be possible. It is important to note that the DEQ's work on these sites has been confined to the City of Detroit only. Any state-wide implementation of such efforts will require resources commensurate to the task.

While resource limitations will compromise our ability to identify and address environmental lead contamination problems, the DEQ remains committed to do all it can to protect Michigan's citizens from lead exposure. We look forward to working with the Commission as it confronts this challenging public health and environmental problem.

Thank you for this opportunity to provide these comments. If you have any questions or require anything further, please contact Mr. Philip Schrantz, of the DEQ's Remediation and Redevelopment Division at 517-241-7706, or you may contact me.

Sincerely,

Jim Sygo
Deputy Director
517-241-7394

cc: Ms. Janet Olszewski, Director, Department of Community Health
Mr. Steven E. Chester, Director, DEQ
Mr. Andrew W. Hogarth, DEQ
Mr. Philip L. Schrantz, DEQ

MICHIGAN LEAD SAFE PARTNERSHIP

18581 Jamestown Circle
Northville, MI 48168

August 2, 2005

Dr. Kimberlydawn Wisdom; Chairperson
Childhood Lead Poisoning Prevention and Control Commission
Department of Community Health
3423 North Martin Luther King Jr. Boulevard
P.O. Box 30195
Lansing, Michigan 48909

Dear Dr. Wisdom and Members of the Commission:

Enclosed is the Michigan Lead Safe Partnership's (MLSP) testimony for the August 2, 2005 hearing of the Childhood Lead Poisoning Prevention and Control Commission. MLSP is a partnership of coalitions, organizations, and concerned citizens from across the State of Michigan.

MLSP is encouraged by the creation of the Commission and is dedicated to lending its support to all effective efforts to end childhood lead poisoning in the State of Michigan. We will continue to explore ideas and develop suggestions for submittal to the Commission's staff or to the Commission at your hearing this fall. If we can be of additional support, please do not hesitate to contact one of our co-chairs.

Sincerely,

Glenn Brown
Partnership Co-chair (Southeast Michigan)
(248) 374-6075

Paul Haan
Partnership Co-chair (West Michigan)
(616) 241-3300

enclosure

Michigan Lead Safe Partnership

testimony to the
Childhood Lead Poisoning Prevention and Control Commission

August 2, 2005

Elimination of Childhood Lead Poisoning by 2010. Prompted by the leadership of the Centers for Disease Control and Prevention, states across the union have drafted and adopted childhood lead poisoning elimination plans. These plans are strategies that will assist each state with eliminating this 100% preventable problem by the year 2010. The State of Michigan has adopted such a plan.

It is the concern of the Michigan Lead Safe Partnership, however, that this goal will not be met without a significantly increased effort to address this problem. While the details of this elimination effort are certainly fought at the local level, there is a clear role for both State and Federal government. The State of Michigan must adopt creative and aggressive policies that assist local communities with getting children tested and making sure homes are repaired and made safe for children *before* they are poisoned. The State must provide fair and adequate resources to get the job done. The Michigan Lead Safe Partnership would like to assist in these efforts.

Economic Benefit of Preventing Childhood Lead Poisoning. Again and again, research has proven that the costs associated with preventing childhood lead poisoning provide an overwhelming cost-benefit to those who invest in prevention.

"In 1989, the CDC estimated that an average of $4,631 was spent on medical care and special education for each severely lead-poisoned child (BPb ≥25µg/dL)"[1]. There were 1,240[2] children with blood lead levels great than 25µg/dL identified between 2000 and 2004 in the State of Michigan. If these 1989 research figures hold true, the cost of medical treatment alone for these children was an estimated $5,742,440. We can only assume that costs today are significantly greater.

Yet there is more to the equation than medical costs alone. The research literature supplies ample evidence that childhood lead poisoning has very real costs in terms of education, social services, lost wages and even corrections.

We know that childhood lead poisoning has an adverse impact upon cognitive development, specifically as measured by IQ. Research has tabulated the cost of this negative impact and the costs are significant. In 2002, total annual economic costs for childhood lead poisoning were estimated to be $43.4 billion nationally[3]. We also know that reduced IQ results in lost worker productivity. It is estimated that for each IQ point lost to lead poisoning, there is a decrease in worker productivity of 1.76-2.38%[4].

> *"Improvements in cognitive ability benefit society by raising economic productivity, including profits and tax revenues, and by reducing crime and other behaviors with negative impacts on others. Because society has borne the costs of preventing lead exposure, through higher prices or lower profits and through public expenditures, examining the benefits from society's perspective makes sense."* (Grosse et al. 2002).

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1 Brown MJ. Cost and Benefits of Enforcing Housing Policies to Prevent Childhood Lead Poisoning. Med Decision Making 2002; Nov-Dec 482-492.

2 Source: Michigan Department of Community Health. Children less than six years of age only, January 1, 2000 through December 31, 2004, unduplicated.

3 Landrigan PJ, Schechter CB, Lipton JM, Fahs MC, Swartz J. Environmental Pollutants and Disease in American Children: Estimates of Morbidity, Mortality, and Costs for Lead Poisoning, Asthma, Cancer, and Developmental Disabilities. Environ Health Perspect 2002; 110(7).

4 Grosse SD, Matte TD, Schwartz J, Jackson RJ. Economic Gains Resulting from the Reduction in Children's Exposure to Lead in the United States. Environ Health Perspect 2002; 110(6): 563-569.

Even an investment in simple changes to housing policy can bear quick economic returns by preventing poisonings. According to the research, appropriate and targeted housing code enforcement has been proven an effective tool in preventing childhood lead poisoning and results in savings from decreased medical and (special) education costs and increased productivity for protected children (Brown 2002).

Lead poisoning will adversely effect the education of many 1000's of Michigan children and their preparation for the work force. Clearly, this loss of productivity will be significant to those children and Michigan's economy.

The Michigan Lead Safe Partnership encourages the Commission to work with us on developing and promoting an economic analysis of the cost/benefit of preventing childhood lead poisoning to the State of Michigan and its citizens.

Specific Action Steps for the Commission. There are very specific action steps that the Michigan Lead Safe Partnership encourages the commission to take. They are as follows:

Immediate Action

- Call upon the Michigan Legislature to restore the $500,000 in funding cuts for childhood lead poisoning prevention being called for in the Senate budget for the Department of Community Health (DCH). *See attachment A*
- Call upon the Michigan Legislature to restore full funding for the Michigan Childhood Immunization Registry (MCIR) and keep this important tool under the management of the DCH. *See attachment A*

Short Term Action

- Pass legislation allowing for the integration of childhood lead poisoning blood lead testing activity and results into the MCIR database. Provide appropriations sufficient to make this change effective by the end of 2005 (estimated at $200,000). *See attachment B*
- Strengthen the testing and follow-up requirements through improved legislation and/or rule making. Make it clear to providers which populations are subject to universal screening and the recommended periodicity of screening. These populations should include Medicaid and all children residing in the thirteen high-risk communities as identified by DCH, as well as all children living in high-risk zip codes. Limit incentives to those providers who do comply with these requirements. *See attachments C & D.*

Long Term Action

- Create a Public Health Trust Fund as called for in the November 2004 Task Force Report. Have the Trust Fund created by 2006. Secure a minimum of several million dollars (not necessarily state budget appropriations) in deposits earmarked for childhood lead poisoning prevention by 2007. Develop funding mechanisms to supply ongoing revenue for childhood lead poisoning prevention by 2007. For example, Michigan should establish fees on sale of paint and other surface coating materials (similar to that adopted New Jersey and Maine). *See attachment E*
- Build upon the 2004 legislation creating a statewide Lead-Safe Housing Registry by enacting legislation to make the Lead Safe House Registry mandatory for all rental property by 2012. Take a reasoned, graduated approach, beginning in 2006, that allows rental property owners adequate time to bring their entire portfolio of pre-1978 housing into compliance. Provide rental property owners who comply with liability protection. Use this registry to prioritize the use of State and Federal resources for tenant-based rental assistance. The Michigan Lead Safe Partnership is willing to assist with drafting and supporting legislation to strengthen the housing registry. *See attachment F*

Attachment A

MICHIGAN LEAD SAFE PARTNERSHIP

18581 Jamestown Circle
Northville, MI 48168

-DRAFT-

Date

The Honorable Name
MI House/Senate
Address
Lansing, Michigan ZIP

Dear Title Name:

This letter is written to express the concerns of the Michigan Lead Safe Partnership (MLSP) regarding two current appropriations proposals.

MLSP objects to the proposed $500,000 reduction in funding for childhood lead poisoning in the Senate appropriations bill for the Department of Community Health (SB 267).

MLSP also objects to the House recommendation to reduce funding for the Michigan Childhood Immunization Registry (MCIR) by $875,000 and shifting operation of this essential public health tool from the State to the HMOs.

The proposed 50% funding reduction for childhood lead poisoning prevention activities is inconsistent with the bold steps and visionary actions that were taken by the 92nd legislature in 2004. This reduction in funding will compromise many of the legislative strategies just enacted:

- Abatement of lead hazards would be severely limited or eliminated.
- Public awareness activities would be severely limited or eliminated.
- Case management for severely lead-poisoned children would be reduced.
- Efforts to build and leverage the essential support of local coalitions in eight high-risk communities would be cut.
- Without effective local coalitions, the ability of communities to capture federal HUD dollars for abatement of lead hazards would be seriously jeopardized. In recent years, three communities were assisted with securing $8 million in federal grants.

Michigan is estimated to have the sixth highest number of lead-poisoned children in the U.S. By continuing the existing funding amounts, Michigan can improve its standing nationally, and continue to evolve as a leader in efforts to eliminate childhood lead poisoning by 2010—the national goal.

Only 15 percent of the State's children under age 6 were tested for lead in 2004. Yet for those tested, 2.5 percent had elevated levels of lead in their blood. In some high-risk neighborhoods incidence rates still exceed 15%. That is one out of every six children permanently and negatively impacted by a preventable poisoning.

We respectfully call upon you to advocate for reinstating $500,000 in funding for childhood lead poisoning prevention in the Department of Community Health budget, for a total appropriation of $1 million.

Keeping consistent with our concern for all of Michigan's children, we stand in solidarity with our colleagues in Flint and request that a grant addressing racial disparity in childhood lead poisoning in that City be reinstated. Flint is one of the high childhood lead poisoning areas in the state.

The proposal to reduce MCIR funding by $875,000 is inconsistent with the House Appropriations Committee's "Results Based Budgeting Framework" goal that "government will be effective, efficient, and accountable." A fully funded, state-managed MCIR is central to ensuring that Michigan's children are fully immunized. Since its inception, the MCIR has ensured a steady increase in immunization levels. *Previously identified as the state with the worst immunization rates,* today Michigan is in the top third of all states for immunization levels, with 81 percent.

This is of additional concern to MLSP because the MCIR is being planned for use in childhood lead poisoning surveillance. With a simple legislative amendment, Michigan could be the first state in the union to have an integrated electronic registry for childhood lead poisoning surveillance. Linking lead to the MCIR is an effective tool that is being urged by doctors, HMOs, public health, communities, parents and children.

To accomplish this, we respectfully call upon you to advocate for fully restored funding for the Michigan Childhood Immunization Registry (MCIR) and keeping this essential public health tool under the management of the Department of Community Health.

Last year, the State of Michigan increased its concerted efforts to end childhood lead poisoning. We have come a long way in our battle to end childhood lead poisoning in the State of Michigan. We have identified and executed effective strategies that are greatly reducing the incidence of this preventable problem. We have reduced the number of children who are impacted by the permanent brain damage caused by lead poisoning. And we know how to completely eliminate this problem in the near future—a solution that will retire the need for both current interventions and future remedial services.

We call upon you to help us finish this work by reinstating these proposed cuts.

If you have any questions about this request, please feel free to contact either of us.

On behalf of the Partnership,

Glenn Brown
Partnership Co-chair (Southeast Michigan)
(248) 374-6075

Paul Haan
Partnership Co-chair (West Michigan)
(616) 241-3300

Attachment B

Fact Sheet
Including Childhood Lead Testing in the Michigan Childhood Immunization Registry (MCIR)

What is the Michigan Childhood Immunization Registry (MCIR)?
The MCIR is a statewide database of all childhood immunization activity. Access to this database is restricted to healthcare providers, public health, and schools ("read only" access) to ensure all children are getting the immunizations needed to protect personal and public health. Since its implementation almost a decade ago, the MCIR has drastically improved childhood immunization rates in Michigan from some of the worst in the nation to some of the best. It can do the same thing for childhood lead testing.

Why Include Lead?
- Pediatricians and physicians are requesting this information.
- Avoid the cost of duplicate testing, especially between managed care and public health programs.
- Removing uncertainty will encourage more doctors and parents to test children.
- The MCIR can be used as a prompt to make sure ALL doctors and parents are following the latest protocol.
- We have the technology that allows us to have this data at our fingertips. We can give providers the most current guidelines and data for follow-up care for lead poisoned children.
- The State is already mandated to keep comprehensive data on both immunizations and childhood lead testing. It makes sense to link this data and to maintain one common database, rather than two.
- Including lead will help Medicaid payment plans come into compliance the State (PA 55 of 2004) and federal Medicaid requirement that require lead testing.
- Avoid unnecessary stress to parents and children.
- Timely and coordinated testing will save the State intervention resources, including the ongoing educational costs required for children with cognitive impairments.
- To protect children from the 100% preventable problem of childhood lead poisoning.

What Needs to Happen?
Two things need to happen in order for childhood lead testing results to be included in the MCIR.
- Legislation will need to be passed revising the MCIR. The legislation that authorized the MCIR restricted it to immunizations only. This statute would need to be updated to allow specified additional uses.
- Preliminary discussions suggest that it will cost about $200,000 to make the technological improvements to link the MCIR with the current childhood lead poisoning database (STELLAR). This one-time cost will allow this system to be fully automated.

Additional Information
- The Lead Advisory Committee of the Michigan Department of Community Health has been discussing the benefit of this change for more than two years now, but legislation has still not been proposed. The community needs action, and would welcome legislation initiated by elected officials.
- Helpful contacts in drafting this legislation would include the following people, both of whom have researched the needed changes to make this proposed change functional:
  - Doug Paterson, patersond@michigan.gov
  - Therese Hoyle, hoylet@michigan.gov

Prepared by: Paul Haan, *Get the Lead Out!* Project Coordinator

PUBLIC HEALTH CODE (EXCERPT)
Act 368 of 1978

333.9207 Childhood immunization registry; establishment; purpose; confidentiality and disclosure requirements; use of information.
Sec. 9207.
(1) The department shall establish a registry, to be known as the "childhood immunization registry", to record information regarding immunizations performed under this part. The department shall enter information received under sections 2821 and 9206 in the registry.
(2) The information contained in the childhood immunization registry is subject to the confidentiality and disclosure requirements of this section and sections 2637 and 2888 and to the rules promulgated under section 9227. The department may access the information contained in the childhood immunization registry when necessary to fulfill its duties under this part.
(3) The department shall use the information in the childhood immunization registry only for immunization purposes. The department shall delete information in the childhood immunization registry pertaining to an individual child immediately upon the child reaching the age of 20.

History: Add. 1996, Act 540, Imd. Eff. Jan. 15, 1997
Popular Name: Act 368

Attachment C

From the 11/16/04 Final Report of the Task Force to Eliminate Childhood Lead Poisoning

Attachment A, p. iii

	Focus Area II: Identifying Those at Risk
Issue	**Recommendation**
Assure compliance with existing requirements/ recommendations	A) Assure compliance with existing requirements /recommendations for lead testing. 1. Identify barriers to testing by primary care providers; develop policies and practices to eliminate barriers to testing in provider offices. 2. Assure that providers understand that collecting specimens and/or packaging /mailing of blood lead samples can be completed without being CLIA certified. Providers should be strongly encouraged to complete specimen collection in their offices. 3. Utilize and share information regarding the availability of the Michigan Department of Community Health laboratory for commercial/public use at $11 per analysis. 4. Provide incentives for providers to comply with testing requirements/recommendations. 5. Assure that Medicaid Health plans test all enrolled children for lead at 1 & 2 years of age.
	B) Provide incentives for parents to comply with testing requirements/recommendations.
	C) Strictly enforce Early and Periodic Screening, Diagnosis, Treatment (EPSDT) screening requirements.

ORIGINAL CONTRIBUTION

Follow-up Testing Among Children With Elevated Screening Blood Lead Levels

Alex R. Kemper, MD, MPH, MS
Lisa M. Cohn, MS
Kathryn E. Fant, MPH
Kevin J. Dombkowski, DrPH
Sharon R. Hudson, RN, MSN, CNM

Context Follow-up testing after an abnormal screening blood lead level is a key component of lead poisoning prevention.

Objectives To measure the proportion of children with elevated screening lead levels who have follow-up testing and to determine factors associated with such care.

Design, Setting, and Participants Retrospective, observational cohort study of 3682 Michigan Medicaid-enrolled children aged 6 years or younger who had a screening blood lead level of at least 10 µg/dL (0.48 µmol/L) between January 1, 2002, and June 30, 2003.

Main Outcome Measure Testing within 180 days of an elevated screening lead level.

Results Follow-up testing was received by 53.9% (95% confidence interval [CI], 52.2%-55.5%) of the children. In multivariate analysis adjusting for age, screening blood lead level results, and local health department catchment area, the relative risk of follow-up testing was lower for Hispanic or nonwhite children than for white children (0.91; 95% CI, 0.87-0.94), for children living in urban compared with rural areas (0.92; 95% CI, 0.89-0.96), and for children living in high- compared with low-risk lead areas (0.94; 95% CI, 0.92-0.96). Among children who did not have follow-up testing, 58.6% (95% CI, 56.3%-61.0%) had at least 1 medical encounter in the 6-month period after the elevated screening blood lead level, including encounters for evaluation and management (39.3%; 95% CI, 36.9%-41.6%) or preventive care (13.2%; 95% CI, 11.6%-14.8%).

Conclusions The rate of follow-up testing after an abnormal screening blood lead level was low, and children with increased likelihood of lead poisoning were less likely to receive follow-up testing. At least half of the children had a missed opportunity for follow-up testing. The observed disparities of care may increase the burden of cognitive impairment among at-risk children.

JAMA. 2005;293:2232-2237 www.jama.com

In 1997, THE CENTERS FOR DISEASE Control and Prevention (CDC) changed the recommendation for childhood lead poisoning prevention from near-universal testing of all children to targeted testing based on the risk of lead exposure.[1,2] This change was motivated by the decrease in the prevalence of lead poisoning because of the success of primary prevention strategies, such as the removal of lead from paint and gasoline.[3] The CDC directed states to develop plans for lead testing according to local risk.[1] Testing was also recommended for children according to the results from a standardized risk-assessment questionnaire and for those enrolled in public-assistance programs (eg, Medicaid; the Supplemental Food Program for Women, Infants, and Children).[1]

An expected benefit of switching to risk-based lead testing, also referred to as lead screening, was to allow greater health care resources to be directed to individuals at greatest risk for lead poisoning. In 1997 and again in 2002, the CDC outlined the role of child health care providers after an elevated screening blood lead level (≥10 µg/dL [0.48 µmol/L]): all elevated screening blood lead test results require diagnostic confirmation, and because capillary sampling has been associated with false elevations, only venous blood should be used for confirmation.[1,4] The urgency for confirmatory testing varies according to the initial level, from 3 months for levels 10 to 19 µg/dL (0.48-0.82 µmol/L) to emergently for children with levels of at least 70 µg/dL (3.38 µmol/L). Once the level is confirmed, repeated testing is recommended, with a frequency ranging from as soon as possible for those with levels of at least 45 µg/dL (2.17 µmol/L) to 3 months for those with levels from 10 to 14 µg/dL (0.48-0.67 µmol/L) to ensure that the blood lead level is not increasing and, if applicable, is responding to intervention.[4] Of note, any repeated testing that occurs after a 6-month break is considered to be a screening test, regardless of the previous lead level, and would therefore require confirmatory testing and subsequent repeated testing as necessary.

Lead poisoning prevention is a collaborative effort between primary care clinicians and public health agencies.

See also p 2274 and Patient Page.

Author Affiliations: Child Health Evaluation and Research Unit, Division of General Pediatrics, University of Michigan, Ann Arbor (Drs Kemper and Dombkowski and Mss Cohn and Fant); and Childhood Lead Poisoning Prevention Program, Michigan Department of Community Health, Lansing (Ms Hudson).
Corresponding Author: Alex R. Kemper, MD, MPH, MS, 6E18 300 N Ingalls Bldg, Ann Arbor, MI 48109-0456 (kempera@med.umich.edu).

Primary care clinicians should ensure that children are appropriately screened for lead poisoning as part of routine preventive care and then receive follow-up testing and care as necessary. State and local public health departments provide and coordinate services for children identified with lead poisoning (eg, environmental investigation, lead abatement). In some communities, public health departments also offer blood lead testing, usually for children who do not have a regular source of medical care.

Because of the harm of even modest elevations in blood lead level,[5] significant efforts have been made to improve screening among at-risk children. However, screening is effective only with appropriate follow-up care. No previous population-based study has evaluated the care that children receive after having an elevated screening blood lead level.

To begin to understand the care provided to children after an elevated screening blood lead level, we chose to focus on one component of care: follow-up blood lead testing. We based our study in Michigan because this state has a reporting mechanism for all blood lead levels, regardless of result, and compared with other states, Michigan has a high number of children with lead poisoning.[6] We chose to study Medicaid-enrolled children because they are at high risk for lead poisoning[7] and because demographic and health care use data are available for these children.

METHODS

Study Design

We performed a retrospective cohort study of children aged 6 years and younger who had an elevated blood lead level (≥10 µg/dL [0.48 µmol/L]) between January 1, 2002, and June 30, 2003, in Michigan and who were continuously enrolled in Michigan Medicaid during the 180-day period after the elevated blood lead level. Because we were interested in newly identified cases of lead poisoning, we excluded children who had an elevated blood lead level reported in 2001.

For each child, we identified the first elevated blood lead level during this 18-month period. We then identified any other blood lead testing during the subsequent 180 days. We chose 180 days because blood lead testing after a 6-month break is considered to be a new screening test and because follow-up blood testing, regardless of the initial blood lead level, should occur earlier.[1] All medical encounters during this 180-day period were identified to determine missed opportunities for follow-up testing.

This study was approved by the University of Michigan Medical School institutional review board, which waived informed consent for this retrospective study.

Data Sources

Demographic, enrollment, and encounter data were obtained from Medicaid program administrative files and were linked to blood lead results collected by the Michigan Department of Community Health (MDCH). Each laboratory in Michigan has been required since 1997 to report all blood lead results to the MDCH. The laboratories supply identifying information about each individual tested (eg, name, address, birth date, Medicaid number), collection date, blood lead level result, and the method of specimen sampling (eg, venous, capillary). These data are entered into an electronic file that is subsequently linked through a complex algorithm to other data sets maintained by the state, including the Medicaid program files.

Bull Services conducted an internal study in 2002 commissioned by MDCH that found the linkage process across all data sets to be more than 99% accurate, with 0.4% false matches and 0.3% false nonmatches (written communication, Tom Rothan, June 2004. This study was undertaken to test the accuracy of the match for purposes of overall calibration of the Unique Client Identifier system. Bull Services Inc believes the study was accurate for that purpose. It was based on a sampling of data and reflected the data sets at the time of the study [2002]. The results of the study were not intended as a guarantee or warranty of accuracy for any selected matching process using Unique Client Identifier at that time or in the future).

Outcomes Measured

The main outcome measures of this study were the proportion of children who had at least 1 follow-up test during the 180 days after an elevated screening blood lead level and the number of missed opportunities among those children who did not have any other follow-up testing. We determined missed opportunities by using claims data, classifying encounter types according to *Current Procedural Terminology* code.[8] Medical encounters were classified as visits for evaluation and management (99201-5, 99211-5, 99354-5), preventive care (99381-3, 99391-3), emergency care (99281-5), consultation (99241-5), and inpatient care (99221-3, 99231-6, 99251-5, 99261-3, 99291-9, 99346-7). We also evaluated the relationship between the screening blood lead level and the first follow-up test result.

Independent Variables

Certain demographic factors are associated with the risk of lead poisoning, including age, race or ethnicity, urban or rural status, and local risk of lead exposure.[7,9] We hypothesized that children with increased likelihood of having elevated blood lead levels (eg, younger children, nonwhite children, children living in urban areas or in communities with a high risk of lead exposure) would also have a greater likelihood of follow-up testing after an elevated screening level. We also hypothesized that there would be differences in follow-up testing rates across local public health department catchment areas. Although there is variation in the proportion of children with elevated blood lead levels across the catchment areas, all local public health departments in Michigan share responsibility with private practitioners in coordinating services for children with

lead poisoning. Finally, we hypothesized that follow-up would be greater among children who had an initial capillary sample or who had higher initial blood lead levels.

In our analysis, we dichotomized race or ethnicity as non-Hispanic white and Hispanic or nonwhite according to classification by parents on Medicaid enrollment forms. Address in the calendar year of the screening test was used to classify urban or rural status, lead-exposure risk, and health department catchment area.

Urban residence was classified according to metropolitan statistical areas (MSAs), as defined by the US Census Bureau.[10] Each MSA is formed around an urbanized area of 50 000 or more inhabitants and includes adjacent communities if they are economically or socially integrated to the urbanized area. Each MSA is composed of 1 or more counties. In Michigan, 26 of the 83 counties are classified as being in an MSA.

Children were considered to have a high risk of lead exposure according to Michigan's targeted screening plan, which categorizes ZIP code areas by the incidence of lead poisoning, the stock of older houses, and the proportion of children living in poverty.[11] In cases of incomplete address information, we used the ZIP code from the following or preceding calendar year in our data set for risk classification. We performed a sensitivity analysis to test the validity of this assumption by reanalyzing the data, omitting children with missing ZIP code data.

There are 45 local health departments in Michigan. To evaluate the effect of health department, we compared the rates of follow-up testing in the 2 local health departments that had the largest number of children with elevated screening blood lead levels with that of the other local health departments.

Other independent variables were the blood sample type (ie, capillary, venous) and the value of the screening blood lead level. We categorized blood lead level to reflect recommended treatment: 10 to 19 µg/dL (0.48-0.92 µmol/L) (follow-up lead monitoring and education), 20 to 44 µg/dL (0.97-2.13 µmol/L) (as per lower levels plus environmental investigation and abatement, and neurodevelopmental monitoring), and at least 45 µg/dL (2.17 µmol/L) (as per lower levels plus chelation therapy).[1,4] Throughout, to convert blood lead levels to µmol/L, multiply values by 0.0483.

Statistical Analysis

Confidence intervals (CIs) were based on a normal distribution for continuous variables and on a binomial distribution for categorical variables. We used 3 measures to evaluate the association between each independent variable and likelihood of follow-up testing: the proportion of children at each level of the variable that had follow-up testing, the unadjusted relative risk (RR) of follow-up testing, and the adjusted RR of follow-up testing. Modified Poisson regression was used to determine the adjusted RRs and their CIs.[12] Variables were also compared with Pearson χ^2 test for categorical variables or t test for continuous variables. Observations with missing data were excluded from bivariate and regression analyses. All reported P values and CIs are 2-sided. $P<.05$ was considered to indicate statistical significance. Stata 8.2 software (StataCorp, College Station, Tex) was used for all analyses.

RESULTS

Study Population and Demographic Characteristics

There were 5175 Medicaid-enrolled children who had a blood lead level of at least 10 µg/dL (0.48 µmol/L) between January 1, 2002, and June 30, 2003. Of these, 3682 (71.2%) did not have an elevated blood lead level during 2001 and were therefore included in this analysis.

The demographic characteristics of these children are listed in TABLE 1. For all but 148 of the children (96.0%), we used ZIP code data from the calendar year of the screening test. For the remainder, we used ZIP code data for the other year during the study period.

One- and 2-year-old children accounted for slightly more than half of the children with elevated blood lead levels. Most children were Hispanic or nonwhite, lived in urban areas, and had high risk of lead exposure.

Race and ethnicity and risk of lead exposure were clustered by urban or rural residence. Compared with rural areas, urban areas had a greater proportion of Hispanic or nonwhite children (88.8% vs 21.0%; $P<.001$) and a greater proportion of children with high risk of lead exposure (96.1% vs 84.9%; $P<.001$).

Most of the children lived within districts served by either of 2 local public health departments, both serving urban areas but on opposite sides of the state. One served the area in which 67.0% of the children lived, and the other served the area in which 14.0% of the children lived.

Screening Blood Lead Level

The screening test was based on a capillary sample for 1543 (41.9%) of the children, a venous sample for 2138 (58.1%) of the children, and unknown for 1 child. The mean blood lead level did not vary according to blood sample type (capillary, 14.7 µg/dL; venous, 14.4 µg/dL; $P=.11$). TABLE 2 lists the categorized distribution of blood lead levels stratified by blood sample type; differences in the distribution were not statistically significant ($P=.39$).

Follow-up Testing

Overall, 53.9% (95% CI, 52.2%-55.5%) had follow-up testing within 180 days of their elevated blood lead screening test, with a mean of 68.5 days (95% CI, 66.3-70.6 days). The mean number of days before the first follow-up test was shorter for capillary (51.5 days; 95% CI, 48.5-54.4 days) than for venous screening tests (83.7 days; 95% CI, 80.8-86.6 days) and for higher screening blood lead levels (10-19 µg/dL: 73.2 days [95% CI, 70.8-75.6 days]; 20-44 µg/dL: 49.2 days [95% CI, 44.4-54.1 days]; ≥45 µg/dL: 10.0 days [95% CI, 5.9-14.0 days]).

Most follow-up tests were done with venous samples (n=1789; 90.2%), in-

cluding 88.4% of the screening tests that used capillary samples (n=829). Mean follow-up blood lead levels were 3.6 µg/dL (95% CI, 3.0-4.2 µg/dL) lower than the screening blood lead level. The mean change was greater for capillary (6.6 µg/dL; 95% CI, 6.0-7.1 µg/dL) compared with venous screening tests (3.0 µg/dL; 95% CI, 2.6-3.3 µg/dL).

On follow-up testing, 47.5% (95% CI, 45.2%-50.0%) of the children still had elevated blood lead levels. Children with screening tests using venous blood compared with capillary blood were more likely to have an elevated lead level on follow-up testing (60.1% vs 33.4%; $P<.001$). Regardless of blood sample type, higher screening levels were associated with a greater likelihood of an elevated follow-up blood lead level (10-14 µg/dL: 32.8%; 15-19 µg/dL: 64.6%; ≥20 µg/dL: 77.8%; $P<.001$).

Table 1. Characteristics of the Study Population and the Associated Likelihood of Follow-up Testing (N = 3682)

Characteristic	Distribution, No. (%)	Likelihood of Follow-up Testing: Proportion (95% CI)	Relative Risk: Unadjusted (95% CI)	Relative Risk: Adjusted (95% CI)*
Age, y				
<1	130 (3.5)	58 (49-67)	0.98 (0.85-1.15)	0.95 (0.92-0.99)
1	1280 (34.8)	59 (57-62)	1.00	1.00
2	827 (22.5)	57 (53-60)	0.96 (0.89-1.03)	1.02 (1.01-1.03)
3	634 (17.2)	53 (49-57)	0.90 (0.82-0.98)	0.96 (0.95-0.97)
4	552 (15.0)	45 (41-50)	0.76 (0.69-0.84)	0.85 (0.81-0.89)
5	204 (5.5)	37 (31-44)	0.63 (0.52-0.75)	0.71 (0.71-0.71)†
6	55 (1.5)	22 (12-35)	0.37 (0.22-0.61)	0.43 (0.42-0.43)†
Race/ethnicity‡				
Non-Hispanic white	479 (13.0)	66 (61-70)	1.00	1.00
Hispanic or nonwhite	3178 (86.3)	52 (50-54)	0.79 (0.74-0.85)	0.91 (0.87-0.94)
Residence				
Rural	100 (2.7)	67 (57-76)	1.00	1.00
Urban	3582 (97.3)	53 (52-55)	0.80 (0.69-0.92)	0.92 (0.89-0.96)
Lead exposure risk‡				
Low	156 (4.2)	65 (57-73)	1.00	1.00
High	3525 (95.7)	53 (52-55)	0.82 (0.72-0.92)	0.94 (0.92-0.96)
Local public health department area				
1	2466 (67)	48 (46-50)	0.81 (0.76-0.88)	0.88 (0.86-0.89)
2	517 (14)	75 (71-78)	1.26 (1.17-1.37)	1.20 (1.17-1.22)
All others	699 (19)	59 (55-63)	1.00	1.00
Initial blood sample type‡				
Venous	2138 (58.1)	49 (47-51)	1.00	1.00
Capillary	1543 (41.9)	61 (58-63)	1.24 (1.17-1.32)	1.11 (1.05-1.16)
Initial blood lead level, µg/dL				
10-19	3205 (87.1)	51 (49-53)	1.00	1.00
20-44	445 (12.1)	71 (67-75)	1.39 (1.30-1.49)	1.36 (1.34-1.39)
≥45	32 (0.9)	94 (79-99)	1.84 (1.67-2.02)	1.82 (1.81-1.82)†

SI conversion factor: To convert blood lead levels to µmol/L, multiply values by 0.0483.
*Adjusted for age, screening blood lead level results, and local public health department catchment area.
†Narrow confidence interval (CI) because of rounding.
‡Missing data: race/ethnicity (n = 25), lead exposure risk (n = 1), and initial blood sample type (n = 1).

Predictors of Follow-up Testing

Table 1 lists the proportion, unadjusted RR, and adjusted RR of follow-up testing by each of the independent variables. Although higher screening levels were associated with increased rates of follow-up testing, not all children in the highest category, at least 45 µg/dL, had follow-up testing. Children who had screening with capillary blood or who had a higher screening blood lead level had a greater likelihood of follow-up testing.

The likelihood of follow-up testing decreased with increasing age after 2 years ($P<.001$). The likelihood of follow-up testing was lower for Hispanic or nonwhite children ($P<.001$), for children with urban residence ($P<.001$), and for children with high lead-exposure risk ($P=.003$). Children living within the area served by the first local public health department had a lower likelihood of follow-up testing than those served by other health departments ($P<.001$). In contrast, children served by the second local public health department had a greater likelihood of follow-up testing than other health departments ($P<.001$) (Table 1). The association between follow-up and these demographic factors persisted after multivariate adjustment.

Sensitivity Analysis

Omitting cases with missing ZIP code data in the year of testing had no significant effect on the overall rate of follow-up testing, the proportion of children in low- or high-risk areas for lead exposure who had follow-up testing, the unadjusted risk of follow-up testing by lead-exposure risk, or any of the adjusted RRs for follow-up testing.

Table 2. Distribution of Screening Blood Lead Levels by Blood Sample Type

Level, µg/dL	Capillary, No. (%) (n = 1543)*	Venous, No. (%) (n = 2138)*
10-19	1331 (86.3)	1873 (87.6)
20-44	196 (12.7)	249 (11.7)
≥45	16 (1.0)	16 (0.8)

SI conversion factor: To convert blood lead levels to µmol/L, multiply values by 0.0483.
*The blood sample type for 1 observation, with a level of 18 µg/dL, was unknown. Differences in the distribution by blood sample type were not statistically significant ($P = .39$).

Missed Opportunities for Follow-up Testing

Among individuals who did not have follow-up testing, 58.6% (95% CI, 56.3%-61.0%) had at least 1 medical encounter during the 180 days after the elevated screening blood lead level, with a mean of 2.3 (95% CI, 2.1-2.4) encounters among those who had any

subsequent encounters. The most common type of medical encounter was for evaluation and management (39.3%; 95% CI, 36.9%-41.6%); however, 13.2% (95% CI, 11.6%-14.8%) had at least 1 preventive care visit, and 26.7% (95% CI, 24.6%-28.8%) had an emergency department visit. Outpatient consultations (2.6%; 95% CI, 1.9%-3.4%) and hospitalizations (2.4%; 95% CI, 1.7%-3.1%) were rare. Among individuals who did not have follow-up testing, 11.4% (95% CI, 10.0%-12.9%) had an emergency department visit as their only medical encounter in the 180 days after the initial elevated blood lead level.

COMMENT

This is the first population-based study, to our knowledge, of follow-up after an elevated screening blood lead level. Although we cannot comment on other interventions that these children may have received for their elevated blood lead level, follow-up testing is the cornerstone of lead poisoning management and an essential component of secondary prevention.[1,4] We found that nearly half of the children in this study had no follow-up testing 6 months after an elevated screening blood lead level result. Furthermore, those children with the greatest risk of lead poisoning according to demographic factors, including nonwhite children, those living in urban areas or in communities with a high risk of lead exposure, and those living in the local public health department catchment area with the greatest number of elevated screening blood lead levels, were the least likely to have follow-up testing. Multivariate modeling demonstrated that these effects are independent; the more demographic risk factors a child had, the less likely the child was to receive follow-up testing. These findings suggest a lack of connection between federal efforts to eliminate childhood lead poisoning[13] and current lead screening practices.

The lack of follow-up testing is likely to have a significant clinical effect. Even modestly elevated blood lead levels have been associated with intellectual impairment.[5] Nearly half of the individuals with follow-up testing had persistently elevated blood lead levels. We suspect that the proportion of children with persistently elevated levels may be even higher in those without follow-up testing because of their greater risk of lead poisoning. The differential pattern of follow-up testing may further disadvantage minority children.

Our study has several limitations. We are unable to determine the cause of the low rate of follow-up testing or its inequitable pattern. Our findings could be biased by inaccuracies in the Medicaid enrollment files, including classification of race and ethnicity. We classified children's residence according to a single address and did not consider the effect of changing residences. Our classification of urban or rural status does not allow us to understand neighborhood-level effects. Finally, we are unable to specify the site of screening or follow-up testing.

Under the current system, primary care providers are responsible for follow-up testing as part of the care provided within the medical home, with local health departments primarily coordinating treatment for children with confirmed lead poisoning. Loss of medical follow-up does not itself account for the low rate of follow-up testing. More than half of the children with no follow-up testing had medical encounters in the 6 months after their elevated screening blood lead level result. However, at least 10% of these encounters were outside of the primary care setting, where there may be no knowledge of the elevated screening level and follow-up lead testing is unlikely to occur. To minimize loss to follow-up because of poor information sharing, New York City has recently integrated blood lead test results into their immunization registry.[14] A similar approach has been proposed in Michigan.[15]

Information-related barriers are unlikely to solely account for the observed disparities. We suspect that elevated screening blood lead levels in children perceived to be at low risk may attract extra attention. In contrast, care may be less aggressive in high-risk populations if lead poisoning is not considered unusual or if resources for optimal care (eg, environmental investigation, lead abatement) are insufficient. Inadequate guideline adherence is not unique to childhood lead poisoning prevention.[16-18] Future research is needed to understand the specific barriers to optimal care for children with elevated screening blood lead levels and to clearly define the responsibilities of public and private health care practitioners.

Childhood lead poisoning is common, affecting 2% of US children aged 1 through 5 years.[6] Furthermore, Medicaid-enrolled children have a 3-fold greater risk.[7] Current federal plans call for the elimination of childhood lead poisoning by 2010,[13] primarily through secondary prevention.[1,4] In this first population-based study of the outcomes of screening, we found that half of Medicaid-enrolled children with an elevated blood lead level have no follow-up testing, and those children at greatest risk of having an elevated blood lead level are less likely to receive follow-up testing. Because each state handles lead poisoning prevention differently, we do not know whether these results are generalizable to other states. We hope that our findings lead other states to perform similar assessments. To maximize cognitive development in these children, it is crucial to improve follow-up and to understand and develop interventions to overcome these unexpected disparities in care.

Author Contributions: Dr Kemper had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.
Study concept and design: Kemper, Cohn, Fant, Dombkowski.
Acquisition of data: Kemper, Cohn, Dombkowski.
Analysis and interpretation of data: Kemper, Cohn, Fant, Dombkowski, Hudson.
Drafting of the manuscript: Kemper.
Critical revision of the manuscript for important intellectual content: Cohn, Fant, Dombkowski, Hudson.
Statistical analysis: Kemper, Dombkowski.
Obtained funding: Kemper.
Administrative, technical, or material support: Cohn.
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Role of the Sponsor: The Michigan Department of Community Health participated in the design of this project, provided the data, and reviewed and approved the manuscript.

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Attachment E

From the 11/16/04 Final Report of the Task Force to Eliminate Childhood Lead Poisoning

Priority Recommendation #3, pp. 5-6.

3. **The Governor should establish a public health trust to serve as a repository for a variety of potential revenues in order to provide a stable ongoing funding stream for the prevention of lead poisoning in children as well as lead remediation and control activities. It is further recommended that the trust be established by legislation or executive order.**

   Securing adequate funding to address lead poisoning is essential if Michigan is to achieve the goal of eliminating lead poisoning in children by 2010. A Public Health Trust could serve as the repository for a variety of revenues that would be utilized for prevention of childhood lead poisoning and addressing environmental hazards.

   In addition to sources of federal funding found in Attachment E (of the 11/16/04 Final Report of the Task Force to Eliminate Childhood Lead Poisoning), other potential funding sources include: fees generated by building and remodeling permits; refinancing transaction fees; fees on paint sales; fees on licenses for building and remodeling contractors; grants from federal and state agencies; foundation grants; donations from corporations and individuals; fees from training programs for Lead Inspectors and Risk Assessors; out-of-court settlements and state General Funds.

   A Public health Trust could hold both restricted (designated by donor or funding agency) and non-restricted funds that could be utilized for a variety of activities to prevent the exposure of children to lead hazards (primary prevention) as well as remediation and control activities designed to reduce environmental hazards. The initial cost of establishing a Public Health Trust, including legal fees and marketing the Trust to potential donors, is **$150,000.** The annual cost of administering the Trust is estimated to be 10-15% of revenues.

Michigan should establish fees on sale of paint and other surface coating materials. This new legislation would be similar to that adopted by New Jersey in 2004 and Maine in 2005. The intent is to finance an array of lead poisoning prevention services such as those that the Task Force identified on page 10 of its final report.

As the Task Force reviewed the recommendations, it was determined that a multifaceted approach must be implemented to achieve the national and state goals of the elimination of lead poisoning by the year 2010. Four major focus areas emerged from this discussion and all recommendations developed by the Task Force and Subcommittees were identified as relating to one of the four focus areas:

- eliminating lead hazards in housing;
- expanding testing of children to determine their blood lead status;
- assuring capacity to serve children who may need special medical and educational services; and
- identifying resources to provide a stable funding stream to address lead hazards and lead poisoning.

These four focus areas became the foundation for operationalizing strategies that will result in a lead-safe environment for the children of Michigan."

Attachment F

Sample Mandatory Lead-Safe Housing Registry - State of Maryland

www.leadsafe.org/Maryland_laws/Env6-8/Env6-8_summary.html

Maryland Reduction of Lead Risk in Housing Program
(Maryland Code: Environment, Sections 6-801 - 6-852; Article 48A, Sections. 734-737; Real Property, Sec. 8-208.2)

In 1994 the General Assembly established the Lead Poisoning Prevention Program for the purpose of reducing the incidence of childhood lead poisoning while maintaining the stock of affordable rental housing. This program requires owners of older residential properties to meet certain risk reduction standards while providing the protection of limited liability for owners who comply. In addition, it provides a mechanism for potentially more affordable insurance for rental units. The Program is administered by the Maryland Department of the Environment.

Definitions:

- "Person at Risk" - A child under the age of six (6) or a pregnant woman who resides or regularly spends at least twenty-four (24) hours per week in an affected property.
- "Resident" - A tenant residing in the unit for more than thirty (30) days or a child under the age of six (6) spending more than twenty-four (24) hours per week in the unit.

The owners of all rental dwelling units built before 1950 must comply with this law. Owners of units built between 1950 and 1978 may choose to comply and thus benefit from limited liability protection.

The law exempts rental units owned or operated by federal, state or local government or by a public, quasi-public, or municipal corporation, provided the property is subject to standards that are at least as strict as the standards established by this law.

To obtain liability protection, owners must do the following:

1. Register all rental dwelling units with the Maryland Department of the Environment before December 31, 1995. Owners who acquire affected property after that date must register within thirty (30) days after acquisition.
2. Beginning February 24, 1996, Property Owners must provide the following two pamphlets to all occupied units: a) "Protect Your Family From Lead In Your Home" and, b) "Lead Poisoning Prevention *Notice of Tenant's Rights*," and notify tenants of lead hazards that may be in their units. Materials must go out to all occupied units. Property Owners may distribute 25% per quarter through the first year. All tenants must be given these materials by February 24, 1997. These materials are available from the Coalition or your local public library.
3. Meet specific Risk Reduction Standards upon each change in tenant occupancy before the unit is re-rented. These standards can be met by either
   a) passing a lead dust "clearance test"
   or
   b) undertaking appropriate lead hazard reduction treatments such as:
   - removing chipping, peeling, or flaking paint,
   - stripping and repainting, replacing or enclosing interior window sills with approved materials,
   - making bare floors smooth and cleanable.
4. Have all "treated" units certified by a MDE-accredited visual inspector.
   Lists of Certified Inspectors may be obtained from the Coalition.
5. Comply with the Modified Risk Reduction Standards when notified of certain conditions such as damaged paint, structural defects, or the presence in the unit of a child with elevated blood lead levels. Tenants are given the right to send Notices of Defects which trigger the performance of the Modified Risk Reduction Standards within thirty (30) days, in most cases.

6. By February 24, 2001 certify that at least 50% of the owner's rental units have received Full Risk Reduction Treatments, and by February 24, 2006 certify that 100% of the units have received Full Risk Reduction Treatments.

Registration
Registration must be renewed annually, and any change in ownership, management, or insurance must be reported within thirty (30) days. Registration forms are open for public inspection, but the Department may not provide a list of properties owned by an individual landlord. However, the Department must disclose, upon request, whether the landlord has registered and complied with certain compliance standards (including the percentage requirements for inventory cleanup). Each time occupancy changes after the first time, the dwelling unit must meet the Full Risk Reduction Standards prescribed by the Department.
Owners are responsible for the cost of temporarily relocating tenants because of a required cleanup, however, tenants are still required to meet normal rent requirements during that time unless an Escrow Action has been filed.

New Tenancy
At the beginning of a new tenancy, the owner must give the tenant the mandated educational materials: a) "Protect Your Family From Lead In Your Home" and, b) "Lead Poisoning Prevention - "*Notice of Tenants' Rights*" prescribed by the Department. New notices and packets must be given to all tenants every two years if there is no change in occupancy. Notices and packets must be sent by certified mail or by a verifiable delivery method.

Repairs and Maintenance
If an owner of affected property undertakes repairs or maintenance that will disturb the paint on any interior surfaces, the owner must make reasonable efforts to ensure that all "persons at risk" are removed from the property while the work is being done, and to ensure that all other persons are not present in the area where the work is being done. Work must be done in a lead-safe manner as specified by Maryland Department of the Environment Regulations (please call the Coalition if you have questions).
Tenant must allow reasonable access so that work can be done.
If it is necessary that the tenant vacate the property for twenty-four (24) hours or more, landlord must pay the reasonable expenses that tenant incurs because of relocation.

Winter Waivers
An owner may apply for a "winter waiver" for work on exterior defects during the period November 1 - April 1 from the local housing authority or the Maryland Department of Housing and Community Development. The postponed work must be done within thirty (30) days after the end of the waiver period.

Landlord's Liability/Qualified Offer
The law provides a detailed formula and definitions for determining the extent to which an owner's liability is limited. With certain exceptions, an owner who is in compliance with the registration, notification, and cleanup requirements is protected by payment caps under a Qualified Offer system. The caps are currently $7,500.00 for uncovered medical expenses and $9,500.00 for rent and relocation costs. Qualified Offers are triggered by an at-risk resident having an EBL of 25 µg/dl (micrograms per deciliter) or greater. Qualified Offers must be made by the Property Owner (or Agent) within thirty (30) days of notice of EBL. The tenant then has thirty days to accept or reject the offer.

Retaliatory Actions Prohibited
The owner of any dwelling units covered by this law may not evict or take any other retaliatory action against a tenant "primarily" as a result of the tenant providing information to the landlord in accordance with this law. Prohibited retaliatory actions include:
1. arbitrary refusal to renew a lease;
2. termination of tenancy;
3. arbitrary rent increase, or decrease in service to which a tenant is entitled, or;
4. any kind of constructive eviction or harassment.

A tenant who was subjected to a retaliatory eviction or other prohibited action is eligible for relief and reasonable attorney's fees and costs as provided in the State law prohibiting retaliatory actions by landlords.

Lead Poisoning Prevention Commission

The law also establishes a broadly representative eighteen (18)-member Lead Poisoning Prevention Commission. The Commission is responsible for studying and gathering information on economic, medical, and other issues relating to the effectiveness of the Lead Poisoning Prevention Program, including the need to expand the scope of the law to cover child care centers, family day care homes, and preschool facilities. Each year, the Commission is to review the implementation of the Program and submit a report to the Governor.

Community Outreach

The Maryland Department of the Environment has the responsibility of establishing community outreach programs in areas of high lead risk, and, if necessary, assisting local governments to provide case management services.

Units Exempted From State Law

- Rental units built after 1978
- Rental units owned or operated by Federal State or Local government or by a public, quasi-public, or municipal corporation, provided the property is subject to standards that are at least as strict as the standards established by this law.
- Rental units certified by a Maryland Department of the Environment accredited inspector to be "lead-free."
- Rental units not considered permanent dwelling units (e.g. vacation homes).